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This thesis examines the impact of the establishment of the Defense Health Program (DHP) Appropriation on the Planning, Programming, and Budgeting System (PPBS) within the Department of Defense. A brief history of the PPBS is presented to explain why the Department of Defense adopted the system in the early 1960's. The PPBS process is then described, with the focus on the Programming portion from a Department of the Navy perspective. The events which led to the creation of the DHP Appropriation are recounted, and the provisions of Program Budget Decision 742 which created the DHP are examined. The effect of the DHP on the PPBS and specifically on preparing the Program Objectives Memoranda (POMs) for fiscal years 1994-1999 and 1996-2001 are then discussed. Finally, problems with using the PPBS to estimate medical program costs and several proposed reforms are addressed.

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The Impact of the Establishment of the Defense Health Program Appropriation on the Planning, Programming, and Budgeting System Within the Department of Defense

by

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of the requirements for the degree of

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ABSTRACT

This thesis examines the impact of the establishment of the Defense Health Program (DHP) Appropriation on the Planning, Programming, and Budgeting System (PPBS) within the Department of Defense. A brief history of the PPBS is presented to explain why the Department of Defense adopted the system in the early 1960's. The PPBS process is then described, with the focus on the Programming portion from a Department of the Navy perspective. The events which led to the creation of the DHP Appropriation are recounted, and the provisions of Program Budget Decision 742 which created the DHP are examined. The effect of the DHP on the PPBS and specifically on preparing the Program Objectives Memoranda (POMs) for fiscal years 1994-1999 and 1996-2001 are then discussed. Finally, problems with using the PPBS to estimate medical program costs and several proposed reforms are addressed.

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TABLE OF CONTENTS

I. INTRODUCTION 1

A. BACKGROUND 1

B. OBJECTIVES 4

C. RESEARCH QUESTIONS 4

D. SCOPE 5

E. METHODOLOGY 5

F. CHAPTER OUTLINE 6

II. PPBS AND THE DEFENSE BUDGET 8

A. HISTORY OF THE PRE-PPB SYSTEM EMPLOYED BY DoD . 8

B. THE CHANGING ENVIRONMENT OPENS THE DOOR FOR PPBS 10

C. THE McNAMARA REVOLUTION 14

D. THE EVOLVING PPBS: 1962 TO THE PRESENT 19

E. SUMMARY 25

III. PPBS SEQUENCE OF EVENTS 29

A. OVERVIEW 29

B. PLANNING 31

1. National Security Strategy 33

2. National Military Strategy Document 33

3. Defense Planning Guidance 35

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C. PROGRAMMING 38

1. Major Programming Documents 42

a. Program Objective Memorandum 42

b. Future Years Defense Plan 44

c. Resource Allocation Display 45

2. Programming Phases 46

a. Program Assessments 46

b. POM Development 54

c. POM Delivery 58

d. OSD Program Review 58

D. BUDGETING 62

IV. ESTABLISHMENT OF THE DHP APPROPRIATION 64

A. RATIONALE 64

B. BACKGROUND 70

C. CHRONOLOGY OF EVENTS 72

D. THE DECISION 79

E. SUMMARY 82

V. BUILDING THE POM FOR THE DHP APPROPRIATION 84

A. BACKGROUND 84

B. ASD(HA) ORGANIZATION TO SUPPORT PPBS FOR THE DHP 87

C. THE EFFECT OF THE DHP ON THE PPBS 89

1. Fiscal Years 1992 - 1993 89

2. PPBS for FY 1994 - 1999 90

3. PPBS for FY 1996 - 2001 97
D. SUMMARY 105

VI. PROBLEMS AND PROSPECTS 112
A. OVERVIEW 112
B. PROGRAMMING FOR AN ENTITLEMENT 113
C. A COMPOSITE MILITARY HEALTH CARE SYSTEM? . . . 119
D. SUMMARY 127

INITIAL DISTRIBUTION LIST. 131

I. INTRODUCTION

A. BACKGROUND

With increasingly tight constraints on available resources to provide for the national defense and the American public's desire to reap a peace dividend after the collapse of the former Soviet Union, the Department of Defense (DoD) must accomplish its mission with greater economy and efficiency. Among the many missions of the DoD is the medical mission, whose function is to provide, and maintain readiness to provide, medical services and support to the armed forces during military operations as well as to members of the armed forces, their dependents, and other beneficiaries entitled to DoD health care.[1]

Management of the medical mission is unique within the DoD. First, as a support mission, it may not receive the attention (in terms of planning and resources) given to the more glamorous missions of DoD such as strategic or general purpose forces. Second, it is unlike the other missions in terms of planning and funding because it is an entitlement program. And third, the medical program must not only compete within the DoD for funding, it must compete against the

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[1]U.S. Department of Defense, *Defense Health Program Amended FY 1992/FY 1993 Biennial Budget Estimates*, p. 1, January 1992.

private sector to prove good stewardship of entrusted funds and personnel.

Medical program funding in the Department of Defense experienced an average annual growth rate in nominal dollars of 8.2 percent from Fiscal Year (FY) 1985 to FY 1991. Although that was below the national health care cost growth rate of ten percent,[2] the DoD budget as a whole did not even keep pace with inflation and grew at less than one percent in nominal dollars over the same period.[3] Given the trend of decreasing defense budgets and increasing health care costs, without a program to identify and contain costs, medical-related expenditures will continue to consume an ever increasing portion of the DoD funding pie.

To address the problem of rising health care costs, Program Budget Decision (PBD) 742 was issued on 14 December 1991 by the Deputy Secretary of Defense to establish the Defense Health Program (DHP) appropriation. This PBD directed that funding in support of the medical mission from Operations and Maintenance (O&M) and Other Procurement (OP) accounts be transferred from the three military departments and consolidated under the control of the Assistant Secretary of Defense for Health Affairs (ASD(HA)). Exempted from the

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[2]U.S. Department of Defense, *Defense Health Program (DHP) Program Objective Memorandum (POM) FY 1994-1999*, p. 1, 1992.

[3]U.S. Department of Defense, Office of the Department of Defense (Comptroller), *National Defense Budget Estimates for FY 1993*, p. 90, March 1992.

consolidation of resources were military personnel, funds and resources in support of field/numbered medical units, hospital ships, and ship-board medical operations.[4]

Under the new organization established by PBD 742, ASD(HA) is ultimately responsible for the submission of a unified medical budget. However, each of the military departments (Army, Air Force, and Navy) continue to plan and assist in programming to meet the medical missions of the DoD. The creation of the Defense Health Program appropriation and the resulting involvement of ASD(HA) in the Planning, Programming, and Budgeting System (PPBS) has therefore created changes for the three services in their PPBS processes.

The PPBS, even without the introduction of the DHP appropriation, is itself continually evolving to meet the needs of the DoD. For instance, the Program Objective Memorandum (POM) for Fiscal Year (FY) 1992 was expanded to cover two years rather than a single year, and the Five Year Defense Plan became the Future Years Defense Plan (FYDP) to reflect the change to a six year plan.

Given the evolution and refinement of the PPBS, there is reason to examine the system and detail the changes in the documents used, the key players, and the sequence of events. The consolidation of the health budgets mandated through PBD 742 provides further need for review of the PPBS

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[4]U.S. Department of Defense, Office of the Deputy Secretary of Defense, *Program Budget Decision 742*, p. 1, 14 December 1991.

process so that the Department of the Navy's Medical community can successfully plan, program, and budget for the necessary resources required to carry out their assigned mission.

B. OBJECTIVES

Although the PPBS has been in use by DoD for over thirty years, it is evolving, as evidenced by the recent changes to the period of time covered by both the POM and the FYDP. The consolidation of the services' health budgets under ASD(HA) as directed by PBD 742 has brought about further changes in the PPBS process. This study will document those changes, give health care professionals an understanding of the process used to create the POM for FY 1994-1999 (POM 94), and the problems and prospects involved in developing the POM for FY 1996-2001 (POM 96).

C. RESEARCH QUESTIONS

How has the decision to consolidate medical resources, as set forth in PBD 742 of 14 December 1991, affected the PPBS employed by the Department of the Navy to ensure that sufficient resources are available to meet health care requirements?

How are medical resource requirements derived from and linked to the appraisals and assessments conducted during the program planning phase?

How does the medical requirements resource sponsor determine the Sponsor Program Proposal (SPP) in response to Chief of Naval Operations (CNO) guidance?

Has medical spending been the subject of special review?

What were the major changes to the Future Years Defense Plan (FYDP) for medical requirement dollars in the most recent Program Objective Memorandum (POM)?

D. SCOPE

The scope of this research will be limited primarily to the Programming portion of the PPBS for the Department of the Navy, with particular emphasis on the POM process and the POM document. Changes in the planning and budgeting portions of the PPBS will only be discussed in the context of the effect they have on programming, or if changes in programming lead to changes in budgeting.

E. METHODOLOGY

Interviews were conducted with personnel from the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)), Office of the Assistant Secretary of Defense (Comptroller)(OASD(C)), Director of Naval Medicine/Surgeon General of the Navy, and the Department of the Navy's Bureau of Medicine. Instructions and regulations governing the PPBS process and other literature examining the process were

reviewed and analyzed. Previous POMs and other related documents used in the programming phase were examined.

F. CHAPTER OUTLINE

Chapter II will provide a brief history of the pre-PPBS system (prior to Fiscal Year 1963) employed by DoD to plan for and allocate the resources required to meet the national security objectives of the United States and the events that led to the implementation of PPBS in the DoD. The major changes to the PPBS since its development for FY 1963 to the present will also be addressed.

Chapter III will explain the PPBS in terms of the sequence of events and the organizations and documents involved. The primary focus will be on the programming portion, with emphasis on both the POM process and the POM document and why they are a significant part of the PPBS.

Chapter IV will discuss the rationale behind the establishment of the Defense Health Program appropriation, with the focus on its role in first making health care costs visible and ultimately in attempting to control those costs.

Chapter V will explain how Programming has changed to accommodate the DHP Appropriation. It will both describe and analyze how the system worked for the first consolidated POM for FY 1994-1999 and how it is projected to work in creating the POM for FY 1996-2001.

Chapter VI will provide an analysis of the problems inherent in programming for the Defense Health Program (DHP) appropriation. It will also discuss health-care related issues such as the creation of a Defense Health Agency and other factors which might affect the organization of the Military Health Services System.

II. PPBS AND THE DEFENSE BUDGET

A. HISTORY OF THE PRE-PPB SYSTEM EMPLOYED BY DoD

The Planning, Programming, and Budgeting System (PPBS) was introduced to the Department of Defense (DoD) in the early 1960's by then-Secretary of Defense Robert S. McNamara. However, the PPB System was not created by the DoD.

In 1907, the first Program Memorandum was developed by the New York Bureau of Municipal Research.[5] The Borough of Richmond, New York City, devised a special program and budget system for street cleaning, highways, and sewers in 1912 to indicate what services would be provided given budgetary constraints. "In the early 1930's, the U.S. Department of Agriculture established a Uniformed Project System that later would be hailed as a forerunner to performance and program budgeting".[6] And in 1938, the Tennessee Valley Authority changed accounting structures to capture financial data in terms of programs such as flood control and fertilizer.[7]

In private industry, DuPont first developed management tools of the program-budgeting type around the time of World

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[5]Lynch, Thomas D., *Public Budgeting in America*, p. 30, Prentice-Hall, 1979.

[6]Lee, R.D. Jr., and Johnson, R.W., *Public Budgeting Systems*, 2d ed., p. 69, University Park Press, 1977.

[7]*Ibid.*

War I, and General Motors incorporated similar techniques at least in the early 1920's.[8]

In the 1940's, the Second Hoover Commission, which was established to report on the organization of the Executive Branch, recommended adopting performance budgeting techniques and organizing budgets into programs. And in the 1950's, the rise of operations research and systems analysis theory, coupled with the increasing computer technology, spurred researchers at the RAND Corporation to develop the framework of what would later become the PPBS for the DoD.[9]

As the U.S. government grew in size and complexity in the 20th century, it became more important to adequately budget expected costs and revenues. It is therefore possible to identify three successive stages of budgetary reform.

The first reform, starting in about 1920 to 1935, emphasized the development of systems to control and record expenditures.

As experience in expenditure accounting was gained, a second reform was born which initiated performance budgeting or budgeting based upon expected levels of production or activities. This second stage developed during the New Deal era and culminated in the movement for performance budgeting nearly a decade later.

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[8]Novick, David, *Current Practice in Program Budgeting (PPBS)*, p. 19, Crane, Russak, 1973.

[9]Lynch, *op. cit.*, p. 30.

The third stage, the emergence of PPBS, was a product of both new information and decision analysis technologies applied to the earlier efforts to link planning and budgeting.[10]

B. THE CHANGING ENVIRONMENT OPENS THE DOOR FOR PPBS

The Planning, Programming, and Budgeting System (PPBS) has been the primary management tool employed by the Department of Defense (DoD) to determine appropriate force structure and levels to meet national security threats within certain resource limitations since the early 1960's. Given that the United States had a Department of Defense prior to the 1960's, the question arises "How did the federal government budget for national defense prior to PPBS?"

Part of the answer is that, prior to the consolidation of the services under the DoD organization, there were two competing Departments: the Department of War and the Department of the Navy. These two departments were wholly separate, both for budgeting and operational purposes.

After the First World War, serious discussion started for the first time about consolidating the two services. Although our involvement in that war was of a short duration, it was quite costly and drew attention to the need for economy and

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[10]See Allen Schick, "The Road to PPB: The Stages of Budget Reform," in Lyden, F.J., and Miller, E.G., eds., *Planning-Programming-Budgeting*, 2d ed., p. 19, Markham Publishing, 1972.

efficiency. The birth of the airplane as a combat weapon had a tremendous impact on the two Departments. While they both struggled to find a mission for aircraft which would further support their separation, many saw aircraft blurring the lines of demarcation.[11]

The two Departments were able to successfully withstand the pressure to unify at that time, and continued to be organized and equipped to accomplish any assigned mission independently of each other. Conduct of joint operations required special agreement between the Secretaries of the Departments or orders from the President. It was not until World War II that joint operations and planning were established to coordinate combined land/sea/air operations.[12]

In December 1945, President Truman proposed to Congress the creation of a single Department of Defense, headed by a Secretary of Cabinet rank, in order to unify the land, sea, and air forces and to integrate strategic plans and unify the military budget.

Truman's proposal came to fruition with the passage of the National Security Act (NSA) of 1947, which created not only the Secretary of Defense (SECDEF) position, but also established three separately organized and administered

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[11]Hitch, Charles J., *Decision Making for Defense*, pp. 12-13, University of California Press, 1966.

[12]*Ibid*. pp. 13-14.

departments (Army, Navy, and Air Force) and the Joint Chiefs of Staff.

The first Secretary of Defense was James Forrestal. In his first year in that position, Forrestal concluded that the SECDEF had virtually no control over any but the most trivial operations of the three departments. In order to be effective, Forrestal argued that the SECDEF must be responsible "for exercising direction, authority, and control over the departments and agencies of the National Military Establishment".[13]

Acting on Forrestal's and others' recommendations, Congress amended the 1947 NSA in 1949, making the SECDEF the principal assistant to the President on defense matters and stripping the three departments of their executive status. This amendment also created the Office of Assistant Secretary of Defense (Comptroller) and provisions for uniform budget and fiscal procedures throughout the Department of Defense.[14]

But strengthening the SECDEF position and creating the OASD(C) did not have an immediate impact on the operations of the three services. The budgeting process, in particular, continued much the same as it had in the past. The President would inform the SECDEF of a budget ceiling or level of expenditures that could be supported in Congress and was, in

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[13]*Ibid.* pp. 14-15.

[14]*Ibid.* p. 15.

the President's judgement, appropriate to meet the security needs of the United States. The funding would be parceled out using a fixed ceiling approach, whereby the departments would receive their funding and then budget.[15]

The problem with this method is that it assumes that funds can be rationally distributed before the need for a program is established.[16] As a result, the services remained essentially independent entities, competing against each other for larger shares of the funding. The emphasis was on developing and winning approval for projects within the services which would guarantee increased budget shares rather than on how new projects related to the overall national security strategy. Because the budget focus was short term (the next fiscal year), projects and weapons systems were undertaken with little or no regard for total cost implications other than to increase future projected budget estimates by the services.[17]

The end result was that the President, Congress, and even the Secretary of Defense had little control over what type of national defense the appropriated funding was buying. Additionally, the budgeting system did not address the roles and missions of the services in a way that they could be

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[15]*Ibid.* pp. 23-24.

[16]Lee and Johnson, *op. cit.*, p. 73.

[17]Hitch, *op. cit.*, pp. 24-25.

viewed in the aggregate to reduce or eliminate duplicate roles or change priorities.[18]

C. THE McNAMARA REVOLUTION

On November 9, 1960, the day after John Kennedy was elected President of the United States, Robert S. McNamara was named the first non-family member to be president of the Ford Motor Company.[19]

After graduating Phi Beta Kappa from the University of California and receiving his Master's degree from the Harvard Business School (where he also taught), McNamara helped implement statistical control into the Army Air Corps during World War Two. When Henry Ford II succeeded his father at the helm of the Ford Motor Company in 1946, McNamara was hired as one of the "Whiz Kids" to help work on his Ford's management problems.[20]

In his fifteen years at Ford, McNamara swiftly rose through the ranks. His strengths were in statistical analysis, finance, and scientific management rather than in the more public fields of engineering and marketing.[21]

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[18]*Ibid*. p. 26.

[19]Trewhitt, Henry L., *McNamara*, p. 5, Harper & Row, 1971.

[20]*Ibid*. pp. 5,7.

[21]*Ibid*. p. 5.

How McNamara's name was added to the talent pool for a possible position in the Kennedy Cabinet is unclear. However, after two personal meetings with the President-elect, McNamara agreed to leave Ford and become the Secretary of Defense (SECDEF).

As he assumed the duties of SECDEF, McNamara concluded that the process the Pentagon was using for budget planning and programming for annual operations and acquisition of new weapon systems was antiquated and ineffective. The system had, in effect, collapsed and was failing to provide useful decision making information. Despite the fact that the National Security Acts had given the SECDEF the power to manage the military, no provisions had been made to give him the necessary management support to properly execute his duties. McNamara wrote:

> From the beginning in 1961, it seemed to me that the principal problem in efficient management of the Department's resources was not the lack of management authority...The problem was rather the absence of essential management tools needed to make sound decisions on the really crucial issues of national security.[22]

The groundwork for the reorganization of the Defense Department budget had been laid by several studies. In 1949, the Hoover Commission on Organization of the Executive Branch of Government had recommended that the government adopt a

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[22]Lee and Johnson, *op. cit.*, p. 83.

budget based upon functions, activities, and projects - which it designated a "performance budget".[23]

In 1954, David Novick of the RAND Corporation presented a study which proposed a method of program budgeting and recommended that it be applied to the Department of Defense. During his indoctrination period, McNamara attended a briefing held by RAND, and was so impressed with the analytical processes, procedures, detailed supporting documentation, and presentation skills exhibited by personnel employed at Rand that, once installed as Secretary, he immediately convinced several key players of RAND to accept positions within the Department of Defense.

Charles Hitch, who was one of the key players McNamara brought from RAND to DoD as Comptroller, was tasked with implementing this new system. Hitch recommended phasing in PPBS over a period of several years, but McNamara decided to speed up the implementation and formulate the budget for fiscal year 1963 in terms of major programs and weapons systems.[24]

McNamara pushed to implement PPBS because he felt the current management system lacked a means of viewing the defense system as a whole. The missions of the three services

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[23]See Virginia Held, "PPBS Comes to Washington," in Davis, J.W. Jr., ed., *Politics, Programs, and Budgets*, p. 139, Prentice-Hall, 1969.

[24]*Ibid.* p. 140.

overlapped in several areas, and the rising cost of weapons systems made it increasingly more expensive to procure duplicate systems. Additionally, the planning horizon for procurement of new technology was lengthening; the development of new weapon systems took longer than ever to design, test, and produce. Finally, the budget ceiling approach was ineffective; funding was given to the departments prior to determining program requirements.[25]

The goal therefore was to link planning with budgeting, which hitherto had operated independently. Not only were these functions done by different groups (planning by the military and budgeting by the civilian sections of DoD), but their focus was different. Budgeting only looked ahead to the next budget year, while the planners were trying to build intermediate and long-term plans.[26]

At least in theory, the Defense PPB System was built upon the Joint Strategic Objectives Plan (JSOP), which had been prepared annually by the Joint Chiefs of Staff (JCS) since 1955-56. The JSOP projected military forces on a multi-year basis, normally for 5-10 years. However, the JSOP was generally a collection of the individual service's inputs with limited guidance from the SECDEF, and tended to identify

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[25]Lee and Johnson, *op. cit.*, p. 88.

[26]*Ibid.* p. 89.

requirements far in excess (on the average 25-35 percent above) of the available resources.[27]

Despite the apparent complexity of PPBS, the potential benefits were obvious. Since the military planning function and the budget function were already well established, the role of programming was to provide a bridge between the two. By creating program packages, military and civilian leaders could view in the aggregate a major program such as strategic forces. Then, for example, they could consider the cost effectiveness of the Navy's Polaris submarines and the bombers and missiles of the Strategic Air Command, and prioritize resource allocations depending on the results. There was no longer any excuse for random overlapping between the services.[28]

PPBS also tried to anticipate the long range plans and costs for each program. Not only would this system bring more order to the systems acquisition and planning process through in-program comparisons, but by extending the planning and preliminary budgeting horizons out to seven or eight years, McNamara hoped to try to contain future unnecessary costs. In the past, the Services had embarked on projects with minimal costs in the first year or two and then, once the project was into development, almost force the Congress and the Secretary

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[27]*Ibid.* pp. 89-90.

[28]Trewhitt, *op. cit.*, p. 86.

of Defense to fund the increasingly costly project. This procedure was called "inserting the thin edge of the wedge".[29]

PPBS also introduced the concept of cost effectiveness to the Department of Defense. The basic concept behind cost effectiveness is to compare different ways of achieving a national security objective and then to determine which alternative provides the most for a given cost or achieves the given objective for the least cost. This procedure is used for all defense programs and, when put together, should generate the most defense out of any given level of available resources or, what is logically equivalent, to achieve a given level of defense at the least cost.[30]

D. THE EVOLVING PPBS: 1962 TO THE PRESENT

The basic structure of the Planning, Programming, and Budgeting System (PPBS) developed by the Department of Defense (DoD) continues as the framework for the planning and execution of the defense program, though various revisions have been made.[31] Schedules for action change time to time, documents and agencies have changed names, and the relative influence of major participants has also been affected by the

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[29]*Ibid.*

[30]Hitch, *op. cit.*, pp. 43, 52.

[31]Lee and Johnson, *op. cit.*, p. 91.

passage of time. However, the basic guiding principles have remained virtually intact for the past thirty years.

The Office of the Secretary of Defense has maintained a leadership role throughout the process. However, the roles played by the Joint Chiefs of Staff, the military services, and defense agencies have all fluctuated.[32]

A significant development early in the Kennedy administration was the influence quickly attained by DoD officials and civilian analysts in performing what had historically been military functions.[33] In particular, the Systems Analysis Office, under the leadership of Alain Enthoven, exerted tremendous power in shaping Secretary McNamara's decisions for resource allocation. Studies presented by this office were relied on much more in the decision making process than military experience and advice.[34]

After McNamara left office, the Systems Analysis Office's function shifted. Today, instead of conducting independent studies on various systems, they review service proposals and have the burden of proof in recommending changes to service

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[32]White, E.T. and Hendrix, COL V.E., USAFR, *Defense Requirements and Resource Allocation*, pp. 10-11, National Defense University, 1982.

[33]*Ibid.* p. 10.

[34]*Ibid.* p. 16.

programs. As a result of this shift in functions, the office has been renamed Program Analysis and Evaluation (PA&E).[35]

Another major change in the 1960's concerned the introduction of fiscal constraints. During McNamara's time in office, the budget ceilings of the pre-PPBS period were dropped. Instead, the focus was on first determining the requirements and then trying to provide for them. In 1969, Secretary of Defense Melvin R. Laird made military planning "the means for fiscal guidance early in the decision making process."[36] The rationale behind this change was that strategy would not be limited by resource constraints. However, the reality was that the resources required to support the strategy were soon out of line with the available resources.[37]

In 1977, Secretary of Defense (SECDEF) Harold Brown attempted to increase the involvement of the Joint Chiefs of Staff (JCS) and the military departments in the planning process through consolidating within a single document the guidance issued from SECDEF to the services. However, the JCS and the military departments were still reactionary; the process was top-down rather than bottom-up. In order to make plans which would resemble those being prepared by the SECDEF,

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[35]Jordan, A.A., Taylor, W.J. Jr., and Korb, L.J., *American National Security: Policy and Process*, 3d ed., p. 199, The Johns Hopkins University Press, 1989.

[36]White and Hendrix, *op. cit.*, p. 16.

[37]*Ibid.*

the JCS was "forced to rely on literature searches of SECDEF speeches, congressional testimony, presidential statements, and NSC [National Security Council] and State Department memoranda, directives, and policy statements to derive and develop implicit national and defense policy."[38]

In 1981, the Deputy Secretary of Defense was made responsible for the management of the PPBS. The Defense Resources Board (now the Defense Planning and Resources Board (DPRB)) was assigned responsibility for the planning phase. This board was comprised of the Deputy SECDEF, the service Secretaries, the Chairman of the JCS, and other key officials involved with the allocation of resources. This change finally gave the military the front-end involvement in the planning phase to ensure that requirements would be more in line with expected resource levels.[39]

Today, strategy in the planning process is initially proposed by the JCS to the National Security Council, SECDEF, and President in the National Military Strategy Document (NMSD). The NMSD does not contain any fiscal constraints. However, the Defense Planning Guidance (DPG), which contains the collective work of the President, SECDEF, the JCS, and the services and is a follow-on document from the NMSD, does provide fiscal constraints in the form of Total Obligation

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[38]*Ibid*. p. 17.

[39]*Ibid*. pp. 10-11.

Authority for each service and serves as the basis for the preparation of the Program Objective Memorandum (POMs).[40]

When PPBS was first initiated by Secretary of Defense McNamara, standard appropriation categories, such as military personnel, operations and maintenance, and procurement were used for planning and budgeting. The introduction of PPBS meant that all forces and systems would now be grouped in terms of their principal mission or output. As a result, although the traditional appropriation categories were and are still used to present the budget to Congress,[41] nine new programs were created by mission role: Strategic Retaliatory Forces, Conventional Air and Missile Defense Forces, General Purpose Forces, Airlift and Sealift Forces, Reserve and National Guard Forces, Research and Development, General Support, Military Assistance, and Civil Defense.[42]

As the roles and missions of the DoD have changed, so have the major force programs. There are now eleven: Strategic Forces; General Purpose Forces; Intelligence and Communications; Airlift/Sealift; Guard/Reserve Forces; Research and Development; Central Supply and Maintenance; Training, Medical and Other General Personnel Activities;

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[40]U.S. Department of the Navy Program Information Center, *PPBS Training Course*, pp. 32-35, March 1993.

[41]Jordan, Taylor, and Korb, *op. cit.*, p. 190.

[42]Held, *op. cit.*, pp. 138-139.

Administrative and Associated Activities; Support of Other Nations; and Special Operations Forces.[43]

The basic documents required for a PPB System have changed their names during the past thirty years, but have performed virtually the same job. The Program Objective Memorandum (POM) was originally called the Program Memorandum (PM) but contained the same type of information (purposes and objectives, costs and effectiveness of alternatives considered). The Future Years or Six Years Defense Plan (FYDP/SYDP) was originally the Multi-year Program and Financial Plan (MYPFP). The MYPFP, like the FYDP, was essentially a rolling multi-year budget that, on the basis of assorted economic and programmatic assumptions, projected for each program category outputs, costs, and required financing for the past year, the current year, the upcoming budget year, and the four out-years.[44]

In summary, there are guiding principles by which the PPBS operates. However, the timing of events and milestones, involvement and influence of various agencies, and the names of certain boards and documents are always evolving to reflect internally and externally imposed changes.

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[43]U.S. Department of Defense, Office of the Department of Defense (Comptroller), *National Defense Budget Estimates for FY 1993*, p. 60, March 1992.

[44]Axelrod, Donald, *Budgeting for Modern Government*, pp. 282-283, St. Martin's Press, 1988.

E. SUMMARY

To be most effective in meeting the national security requirements of the United States, the combat operations of the three services must be unified. This goal can only be achieved if the planning of the forces and the allocation of resources to meet those plans are also unified in some way. There are many factors at work today which promote the need not only for joint military operations but also a centralized planning program. The collapse of the Soviet Union and the Warsaw Pact, the great cost of military technology, and the combination of an unprecedented federal deficit leading to large defense budget reductions all speak to a need for a rational means of providing the best military, able to respond to any given national security threat, within the constraints of the projected levels of funding.

The Department of Defense (DoD) faces many difficult and unique challenges in defining the new threat environment, developing a strategy to counter the threats, and planning and budgeting for the force structure and levels to meet those threats.

For the first time in nearly half a century, the Soviet Union is no longer the dominant threat against which U.S. forces train to fight. Instead, the force structure of the future must be designed to respond to any number of small regional conflicts. With fierce national debate over spending priorities and deficit reduction plans, force levels will also

be considerably smaller. Given this climate of threat uncertainty and deep budget cuts, how can DoD meet the national security objectives of the United States while staying within the fiscal limitations recommended by the President and imposed by the Congress?

The Planning, Programming, and Budgeting System will be the primary management tool used by the Department of Defense to respond to the changing environment. Planners will determine, primarily through the Defense Planning Guidance (DPG), what threats need to be met. Programmers will estimate the forces and required resources necessary to meet those threats. Finally, a budget process will attempt to ensure that adequate resources are made available to meet the program objectives.

In this way, PPBS transforms force requirements into budget requirements and attempts to project long-range plans, both in terms of force structure and their fiscal implications.[45]

From start to finish the PPBS process takes several years and involves, among others, the Office of Budget and Management (OMB), Office of the Secretary of Defense (OSD), Joint Chiefs of Staff (JCS), and the Service Secretaries. Field activities, although limited participants, play a role by making inputs to their major claimants.

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[45]Hitch, *op. cit.*, p. 39.

The Planning, Programming, and Budgeting System focuses on long-range objectives as well as the resources required to support them. It does not use the baseline method, whereby budgets are incrementally adjusted each year for inflation or budget cuts. Instead, PPBS provides a bridge between planning and budgeting called programming, which is basically a procedure for distributing available resources equitably among the many competing or possible programs.

The ultimate goal of PPBS is to provide DoD with a rational means of distributing scarce resources to different alternatives identified to meet the national security objectives of the United States.[46]

Whether or not the PPBS can respond quickly enough in this time of rapid change is uncertain. The bureaucracy may be such that, by the time a plan reaches the budgeting phase, it is obsolete or fundamentally changed in a way that dramatically affects the budget.

PPBS also relies upon a substantial amount of guesswork. Although rooted in systems analysis, where quantitative results can be achieved to make decisions, national security still relies on some non-quantitative analysis. For instance, the kickoff point for programming is the DPG. Because no one is blessed with a crystal ball, some threats may arise in the future which were not anticipated today. The leaders of the

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[46]*Ibid.*

U.S., while able to analyze certain quantitative figures, must also rely on experience, intelligence, history, and intuition in making threat assessments.

But the PPBS does provide a framework for making the tough decisions that lie ahead. Without the analytical foundation of systems analysis inherent in PPBS, it would be difficult to make sound objective choices among the alternative means of responding to the changing threat given reduced funding. With PPBS, the Secretary of Defense has a set of tools that allows him to take the initiative in the planning and direction of the entire defense effort on a unified basis. And, as it has in the past, PPBS will continue to evolve to meet the management needs of the DoD leaders.

III. PPBS SEQUENCE OF EVENTS

A. OVERVIEW

The Planning, Programming, and Budgeting System (PPBS) is a cyclical process comprised of three distinct but interactive phases: planning, programming, and budgeting. The PPBS provides a framework for Department of Defense (DoD) leadership to make rational decisions on future programs. PPBS also provides for a process to examine and analyze prior decisions in response to changes in national security priorities, the economy, and the political environment.

The three processes in the PPBS are based on objectives, policies, priorities, and strategies derived from national security decision directives. The Secretary of Defense (SECDEF) provides centralized policy direction throughout the PPBS process while delegating program execution authority and responsibility to the DoD Components. The DoD Components, in turn, provide advice and information as requested by the Office of the Secretary of Defense (OSD) to permit the latter to assess budget execution and accountability. Communication and cooperation between OSD and DoD Components are vital in providing the operational commanders-in-chief (CINCs) with the best combination of forces, equipment and support attainable within resource constraints.

This chapter will be a snapshot of the PPB System used by the DON to create the Navy POM. It will examine the organizations involved, the sequence of events, and the documents prepared to support the Department of Defense's (DoD) portion of the President's budget submission to Congress.

Maintaining control and direction over the process can be difficult and confusing. Timely publication of PPBS documents is critical to the management of DoD because the three phases operate on a near-continuous basis and often overlap each other, although not for the same Fiscal Years (FY).[47]

For example, in September 1992, the following processes were taking place:

- Budget execution for the remainder of FY 1992
- Congressional debate on the budget for FY 1993
- Budget revisions for FY 1994-1995
- Program Objective Memorandum (POM) development for FY 1996-2001

Therefore, although this chapter will focus primarily on the Programming portion of the PPBS for the Department of the Navy (DON), in order to fully understand the events which occur in the Programming phase, it is necessary to have an understanding of the Planning and Budgeting phases (the inputs to and the outputs of Programming).

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[47]U.S. Department of Defense Instruction 7045.7, "Implementation of the Planning, Programming, and Budgeting System (PPBS)", p. 2-3, May 23, 1984.

The information presented is based upon the recent experiences in completing the POM for FY 1994-1999 (referred to as POM 94) and also incorporates subsequent changes which have been made for the preparation of POM 96 (FY 1996-2001). Examining the PPBS process used to prepare POM 94 is important in that it produced the first POM prepared for the new Defense Health Program (DHP) appropriation. Chapter V will deal specifically with the PPBS process used to develop the Navy's input to the Assistant Secretary of Defense (Health Affairs)' POM 94 submission.

B. PLANNING

Planning is the first phase of the PPBS. The goals of the planning process are to:

- Examine the world security environment
- Identify national security interests
- Define the national military strategy
- Plan the future force structure two to eight years in advance to successfully execute the strategy within the given resource constraints[48]

Figure 3-1 provides an overview of the planning phase and how it leads to the development of the services' POMs.

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[48]U.S. Department of the Navy Program Information Center, *PPBS Training Course*, p. 29, March 1993.

Figure 3-1

Source: *PPBS Training Course, op. cit.*, p. 30

1. National Security Strategy

The kickoff point for the planning process is the President's National Security Strategy (NSS). The President receives information from a wide variety of sources, including the State Department, the National Security Council (NSC), the Congress, and other executive agencies such as the Central Intelligence Agency (CIA) and Defense Intelligence Agency (DIA). The information, data, and intelligence gathered by these agencies is evaluated in terms of the known capabilities of potential adversaries, current international defense policy objectives, and the current defense posture of the United States.[49]

After reviewing this information, the National Security Strategy document is created. The NSS document reviews global and regional trends; identifies national interests; states political, economic, and defense strategies for the 1990's; and outlines defense strategies for nuclear deterrence, forward presence, crisis response, and reconstitution.[50]

2. National Military Strategy Document

Upon receipt of the President's NSS, the Chairman of the Joint Chiefs of Staff (CJCS) begins to formulate the National Military Strategy Document (NMSD). The NMSD, formerly

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[49]DODINST 7045.7, *op. cit.*, p. 3.

[50]*PPBS Training Course, op. cit.*, p. 31.

called the Joint Strategic Planning Document (JSPD), is the Joint Chiefs of Staff's (JCS) advice to the President, the National Security Council (NSC), and the Secretary of Defense (SECDEF) on national military strategy and force planning guidelines for the fiscally constrained force structure required to meet national security objectives. It is a comprehensive military appraisal of the worldwide threat to U.S. interests, and includes recommended military objectives and strategies to achieve national goals. The NMSD determines the base force at the macro level (such as numbers of ships, airwings, or divisions) and assigns these forces into four military force packages (Strategic, Atlantic, Pacific, and Contingency).[51]

Based upon the NMSD, each service may create their own specific strategy and policy documents. For example, the Navy released "From the Sea, Preparing the Naval Service for the 21st Century" in September 1992.[52]

Both the President's National Security Strategy and the CJCS's National Military Security Document are then used as inputs by the SECDEF in creating the Defense Planning Guidance (DPG).

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[51]*Ibid.* p. 32.

[52]O'Keefe, S., Kelso, F.B. II, and Mundy, C.E. Jr., "...From the Sea: Preparing the Naval Service for the 21st Century," Department of the Navy, September 1992.

3. Defense Planning Guidance

The Defense Planning Guidance (DPG) is a highly influential document in the PPBS. As the final output of the Planning phase, the DPG is the document upon which all DoD program development is based.

The DPG is the first document in the PPBS process to bring fiscal and resource guidance into planning. Fiscal guidance is provided in terms of Total Obligational Authority (TOA) for the next six years. The TOA is the total amount of funds available for programming in a given year, regardless of the year the funds are appropriated, obligated, or expended. This guidance provides overall funding constraints for each service; however, it does not dictate the programs into which the services must allocate their funding.

The principal drafter of the DPG is the Under Secretary of Defense for Policy (USD(P)). Through reviews and comments, SECDEF, the JCS, Service Secretaries, Commanders-in-Chiefs (CINCs), the National Security Council, the Office of Management and Budget (OMB), and the State Department all provide inputs into the Defense Planning Guidance.[53]

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[53]*PPBS Training Course, op. cit.*, p. 34.

The DPG provides guidance from the Secretary of Defense to the services on preparation of their POMs. For example, the DPG for FY 1994-99 contained the following information:

- Defense Policy Goals
- The Regional Defense Strategy
- Regional Goals and Challenges
- Programming for the Base Force
    - * Four pillars (readiness and manpower; sustainability [including infrastructure and overhead]; force structure; and modernization [including systems acquisition, science and technology])
    - * Specific guidance for each pillar
    - * Navy base force (12 carrier battle groups, 11 active/2 reserve air wings)
    - * Direction for force structure programming by strategic element for each service[54]

Annex A of the Defense Planning Guidance provides illustrative planning scenarios for sustainment, readiness, and other purposes. The Annex does not contain technical or analytical information, nor does it make predictions of future events. However, it does provide for the kinds of crises in which the U.S. might be involved and the types of capabilities required to respond to those crises.[55]

As issues arise during the development of the DPG, they are brought forward and discussed with members of the

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[54]*Ibid.* pp. 34-35.

[55]*Ibid.* pp. 34, 36.

Defense Planning and Resources Board (DPRB). The DPRB is a high level committee that is active in all three phases of PPBS. Its functions are as follows:

- Review proposed planning guidance
- Resolve major program and budget issues
- Advise the SECDEF on policy, planning, program, and budget issues/proposed decisions
- Direct evaluations/reviews of high priority programs on a regular basis

The DPRB membership includes:

- DEPSECDEF (Chairman)
- Assistant Secretary of defense (Program Analysis and Evaluation)(ASD(PA&E))
- Service Secretaries
- Under Secretary of Defense (Policy)(USD(P))
- DoD Comptroller
- Under Secretary of Defense (Acquisition)(USD(A))
- Invited Service Chiefs, CINCs, and other DoD leadership
- Chairman, Joint Chiefs of Staff (CJCS)
- Executive Assistant: Special Assistant to DEPSECDEF[56]

Once developed, the draft DPG is presented to the SECDEF and to the CINCs of the unified commands. The CINCs are given the opportunity to make comments on the draft DPG and personally meet with the SECDEF and the DPRB to discuss their views and recommendations.[57]

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[56]*Ibid.* p. 38.

[57]DODINST 7045.7, *op. cit.*, p. 2-1.

The draft DPG is then reviewed by the Executive Committee (EXCOM) of the DoD. The EXCOM provides the SECDEF the opportunity to receive in confidence and with candor the advice, opinions, and judgements of the Secretary's senior advisors. Membership in the EXCOM consists of SECDEF, DEPSECDEF, Service Secretaries, CJCS, Under Secretary of Defense (Acquisition), and the Under Secretary of Defense (Policy).[58]

After considering the advice from the DPRB and the EXCOM, the SECDEF makes the required changes and signs the document. The signed DPG becomes the final product of the planning phase and the basis for the programming phase.

C. PROGRAMMING

Programming is the portion of the PPBS which links planning to budgeting. It converts the DPG and other plans into time-phased and fiscally constrained programs. Each service has developed its own procedures to support the Programming Phase of PPBS. While the other services build their POMs around initiatives originating with their field commands, the Navy process is driven from the top-down.[59] However they derive their inputs, all the services ultimately

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[58]*PPBS Training Course, op. cit.*, p. 39.

[59]Center for Naval Analyses, *Building the Navy Program Objectives Memorandum: The Navy's Programming Process*, p. 16, Alexandria, VA, CIM-82, June 1990.

produce a Program Objective Memorandum (POM) for review and adjustment by the Secretary of Defense (SECDEF). For the Department of the Navy (DON), the programming system is the process by which decisions are made by the Chief of Naval Operations (CNO), Commandant of the Marine Corps (CMC), Secretary of the Navy (SECNAV), and SECDEF concerning modernization (including Research and Development), force levels, readiness, and sustainability for the Navy.

The DoD Programming System is designed to accomplish the following eight objectives:

- Relate resources to defense missions and requirements
- Link planning to budgeting
- Establish programs oriented towards mission objectives rather than service parochialism
- Provide a framework for inter-Service competition to provide required mission forces
- Establish a rational program structure which encompasses all defense activities
- Ensure that cost effective studies support optional force structure or weapons systems proposals
- Evaluate programs on a continuous basis
- Establish a single channel for major decisions on defense programs[60]

Programming works on a two-year cycle. It starts with the last four years of the program developed in the previous PPBS cycle. For example, POM 92 covered FY 1992-1997. When the

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[60]U.S. Department of the Navy, "Program Planning and Development Division (N801) Desk Top Guide," p. 3-1, rev. 17 February 1993.

programming phase began for POM 94, it started with an assessment of the programs developed for the last four years of POM 92 (FY 1994-1997). Those four years are updated and programs developed for the following two years to produce an updated six year program to cover FY 1994-1999. The final POM 94, with its resulting changes (which will be discussed later), then becomes the starting point for the budget process.[61]

The Navy programming process involves several key players. The customers are the commanders-in-chief (CINCs) and the Major Claimants. The Major Claimant for Navy medicine is the Bureau of Medicine (BUMED). Major Claimants provide field inputs to their Resource Sponsors for inclusion in the programming process.

The Resource Sponsors are responsible for aggregating resources which serve as inputs to Warfare and Supporting Warfare tasks. Their resources may be required to support a number of programs in different mission areas. Therefore, they must be able to establish effective and balanced programs within their fiscal guidance. For Navy medicine, the Surgeon General of the Navy (N093) is the Resource Sponsor. His largest claimant is BUMED, but he must also program for the allocation of resources to other claimants reporting to him (e.g. NAVOSH).

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[61]*PPBS Training Course, op. cit.*, p. 44.

Once Resource Sponsors have developed their programs, Assessment Sponsors will check the programs. Organizations in the Office of the Chief of Naval Operations (OPNAV) such as Deputy Chief of Naval Operations for Manpower and Personnel (N1) and Deputy Chief of Naval Operations for Logistics (N4) act as Assessment Sponsors. The assessments cut across Resource Sponsor lines to ensure that there is standard programming for common functions.[62]

Managing the programming process for the Navy are two offices in OPNAV under the Deputy Chief of Naval Operations for Resources, Warfare Requirements, and Assessments (N8): the Programming Division and the Assessment Division. The Programming Division (N80) issues POM Serials to define programming procedures and to set scheduled completion dates; develops program and fiscal guidance to reflect planning decisions; collates changes to budget submissions; and completes final pricing and balancing adjustments after program approval. The Assessment Division (N81) conducts War Games, the Investment Balance Review, and Assessments to check for program balance and to make trade-offs between programs in order to meet guidance set forth in the Defense Planning Guidance and to produce one complete Navy investment strategy.[63]

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[62]*Ibid.* p. 45.

[63]"N801 Desk Top Guide," *op. cit.*, pp. 3-4, 5.

As previously stated, fiscal guidance during the programming phase is provided in terms of Total Obligation Authority (TOA). In order to achieve balanced programs, TOA is viewed from the following different perspectives:

- Mission Assessment (e.g., Joint Strike)
- Pillars (Force Structure, Modernization, Readiness, Sustainability)
- Appropriations (e.g., SCN, MPN, O&MN, MILCON)
- Resource Sponsors (e.g., N093)
- Defense Mission Categories (e.g., the medical function is part of Defense Mission of Major Force Program 8)
- Major Claimants (e.g., BUMED)[64]

1. Major Programming Documents

Programming results in the development of three major documents: the Program Objective Memorandum (POM); the Future Years Defense Plan (FYDP); and the Resource Allocation Display (RAD).

a. Program Objective Memorandum

The Program Objective Memorandum (POM) is the document in which each military department and defense agency recommends and describes its total program within the resources and policy parameters specified by the DPG. It provides force level objectives approved by SECNAV for six years of the PPBS cycle and will describe major system new

[64]*PPBS Training Course, op. cit.*, p. 46.

starts and significant base or force structure changes for a ten year period beyond the year of the POM.[65]

The POM is the SECNAV's annual recommendation to SECDEF for the detailed application of Department of the Navy resources. It covers the objectives, planned activities and cost of each program. The first two years of the POM are used to develop the budget that is submitted to Congress.

During the programming phase, information on current and proposed programs is compiled in the POM and thoroughly reviewed. Part of this review is an assessment of risks and an evaluation of the military advantages and disadvantages of each alternative that has been proposed to meet the risk.[66]

Commands and field activities update their program plans to reflect changing international and national situations, SECDEF guidance, and technological developments. The Navy programs are often rebalanced or changed. The POM has fiscal constraints, but sponsors can rebalance programs within the total available resources to create more balanced programs because appropriation controls have not yet taken effect.

While the POM contains six years of financial information, the primary focus is on the first two years which will become the basis for building the next budget submission.

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[65]"N801 Desk Top Guide," *op. cit.*, p. 3-7.

[66]DODINST 7045.7, *op. cit.*, p. 4.

For example, the first two years of POM 94 (FY 1994-1999) will be used as the basis for the 94-95 budget.

b. Future Years Defense Plan

The Future Years Defense Plan (FYDP) is a current summary of all DoD programs over an eight year period. It relates manpower and financial resources to military programs. The FYDP describes accomplishments to date (previous and current years) and future goals in support of national strategies.

The Program Element (PE) is the basic building block of the FYDP. Program Elements consist of forces, manpower, and estimated costs associated with an organization, a function, or a project. Each PE describes a mission and the responsible organization. For example, PE 0807796D refers to Base Operations - Health Care in the Operations and Maintenance appropriation for the Defense Health Program appropriation.[67]

PEs can be aggregated in the following formats:

- Total resources assigned to a specific program
- Weapons systems and support systems within a program
- Specific resources
- Logical groupings for analytic purposes
- Selected functional groupings of resources[68]

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[67]U.S. Department of Defense, Office of the Deputy Secretary of Defense, *Program Budget Decision 742*, 14 December 1991.

[68]DODINST 7045.7, *op. cit.*, p. 5-4.

Currently, there are approximately 3,000 PEs in the FYDP, including about 1000 Navy PEs (of which about 300 are for RDT&E activities). A Program may consist of several PEs developed to accomplish a defined objective.[69]

The FYDP is a compilation of the decisions that have been approved by SECDEF on the DoD's total program for the future. It is an integrated and coordinated program document that displays forces, costs, manpower, procurement and construction in the approved programs. The costs of programs are displayed for an eight year period (prior, current, and next six years). Major items, such as aircraft, are displayed for an additional three years.

The FYDP is prepared in two ways: by Major Force Program for internal DoD program review, and by appropriation structure for Congressional budget and appropriation review.[70]

c. Resource Allocation Display

The Resource Allocation Display (RAD) is a computerized spreadsheet showing the allocation of Navy resources by:

- Resource Sponsor
- Claimant
- Program Element
- Appropriation

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[69]"N801 Desk Top Guide," *op. cit.*, p. 3-1.

[70]DODINST 7045.7, *op. cit.*, p. 5-1.

- Naval Warfare Task
- Line item (for procurement purposes) or Activity Group (for O&M)

The RAD is frequently updated and printed during the programming phase and reflects the most current FYDP data. RADs are identified by Roman numerals, with odd-numbered RADs being sorted by resource sponsor and even-numbered RADs by claimant. For the Navy, RADs IX and X are the POM as it is submitted to SECDEF.[71]

2. Programming Phases

The programming phase consists of four parts: Program Assessment, POM Development, POM Delivery, and OSD Program Review. These processes combine to convert information from the planning phase into realistic and viable programs.

a. Program Assessments

The Program Assessment phase, shown in Figure 3-2, appraises warfare and support programs and assesses the condition and state of the Navy. Program Assessments are conducted prior to the issuance of the Defense Planning Guidance (DPG).

A new programming cycle begins with the issuance of the first memorandum of the POM Serial. POM Serials form a set of instructions to establish Navy procedures for participation in the planning and programming processes of DoD. They are

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[71]*PPBS Training Course, op. cit.*, pp. 74-75.

Figure 3-2

Source: *PPBS Training Course, op. cit.*, p. 51

issued by the Director, Programming Division (N80), under the direction of the CNO. The memoranda encompass CNO programming and fiscal guidance as well as procedural guidance. Whenever changes to the programming process occur, new POM Serials are issued to the participants to provide updated direction and guidance. Each memo is consecutively numbered to ensure each office has the most up-to-date information.[72]

The first POM Serial (for POM 94 it was POM 94-1) details the structure and provides guidance for the POM development process. It assigns responsibility to appropriate offices and provides instructions and schedules for the programming phase.[73]

One of the first major steps in the program assessment phase is the voicing of CINC Maritime Concerns, which provides an opportunity for the unified commanders (such as CINCLANT) to address both the threats and the ability of the forces to meet the threats based on their operational experience and assessments. Particular emphasis is placed on changes in the national security threats since the last program review and other issues for study as requested by the CNO. This stage of

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[72]"N801 Desk Top Guide," *op. cit.*, p. 3-3.

[73]U.S. Department of the Navy, Office of the Chief of Naval Operations, *Procedures for Program Objectives Memorandum (POM) 94*, Serial 801C/0U651531, 23 August 1990.

the Program Assessment phase allows an off-year preview of priority concerns.[74]

The Program Review and Apportionment Review phases are used to update the most recently completed POM. While the Program Assessment phase is being conducted to compile and review information for the forthcoming POM, the Resource Sponsors, such as the Surgeon General of the Navy, are offered an opportunity in the Program Review phase to review the second year of the President's budget. For example, POM 94 leads ultimately to the President's budget submission for fiscal years 1994 and 1995. During FY 1994, the Program Review phase will allow a resource sponsor to look at the proposed budget for FY 1995. If changes are required, the resource sponsor will prepare Sponsor Change Proposals (SCPs) to propose adjustments to the President's budget submission for FY 1995.[75]

Once all the SCPs are completed, the Apportionment Review is conducted by the Comptroller of the Navy (NAVCOMPT). This review covers current and prior year budget execution. As in the example above, NAVCOMPT would review actual budget execution to date in FY 1994, and make recommendations for reallocation of funds for both FY 1994 and 1995 based on the execution.

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[74]CNA, *Building the Navy POM, op. cit.*, p. 16.

[75]*PPBS Training Course, op. cit.*, p. 77.

In an effort to move Navy POM development and analysis closer to the organization and process used in the Joint Staff Offices, Naval Warfare Appraisals are now Mission Area Assessments. Mission Area Assessments are comprised of Joint Mission Area (JMA) and Support Area (SA) Assessments and are intended to provide an overview of the current Navy structure and assess joint capabilities and requirements, cutting across both resource sponsor and warfare lines. The JMAs and SAs will be the cornerstones of the POM process, replacing the "Warfare Area" and "Pillar" breakdowns of the Navy data base as building blocks. The JMA and SA Assessment process is ongoing and continues throughout the planning and programming cycle.

The six JMAs and two SAs, with the organizations responsible for their preparation in parentheses, are:

Joint Mission Area Assessments:

- Joint Strike (N88)
- Joint Littoral Warfare (N85/N86)
- Joint Surveillance (N87/N88)
- Joint SEW/Intelligence (N6)
- Joint Deterrence (N87)
- Strategic Sealift/Protection (N86)

Support Area Assessments:

- Readiness and Support and Infrastructure (N1/N7)
- Manpower, Personnel, and Shore Training (N81)[76]

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[76]"N801 Desk Top Guide," *op. cit.*, p. 3-3.

Claimant Program inputs provide major claimants the opportunity to submit issues relevant to day-to-day operations. These are issues that are beyond the capability of the claimant to resolve, have implications for many Navy programs, or are of such magnitude that they will have a significant effect on the total Navy program. Each claimant may identify 25 prioritized issues, accompanied by program/financial effects. They are forwarded to CNO (N80) who distributes them to the appropriate resource sponsor. Resource sponsors must address the top five issues identified through this process.

POM Issue Papers provide another opportunity for input by claimants and component commanders to their resource sponsors. In POM Issue Papers, claimants/component commanders document five or more issues or requests for changes in programs. Issue Papers provide the resource sponsors with an early understanding of claimants' concerns and priorities. The claimant must prioritize the issues and recommend a reallocation of resources from a lower-priority program, or identify cost-savings associated with their proposal.[77]

War Games are new decision process tools that have been added to the Program Assessment phase. Policy and programmatic issues are discussed by personnel from the Office of the Chief of Naval Personnel (OPNAV), Marine Corps

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[77]CNA, *Building the Navy POM, op. cit.*, p. 20.

Headquarters (HQMC), and Fleet and Fleet Marine Force (FMF) representatives. They integrate the JMAs and SAs, checking for program balance, and make trade-offs between programs as required. Capabilities are then played in War Games conducted by N81 (Assessment Division) in terms of scenarios as set forth in the Defense Planning Guidance (DPG).[78]

Integrated Priority Lists (IPLs) provide operational commanders-in-chief (CINCs) the opportunity to submit prioritized issues via the appropriate component command. For example, CINCLANT would submit an IPL through CINCLANTFLT. CINCs are not limited in the number of issues they can submit, nor are they required to identify offsets as the claimants are. Official feedback must be provided to the CINCs on the disposition of their IPLs in the building of the POM.[79]

Baseline Assessments identify the minimum required resources to support a specific program or set of programs at a stated force level. These Assessments support resource sponsors in the development of programs by providing rational baseline costs for projected force levels and associated support needs. They address programs which cut across several resource sponsors and are issued in the form of a Baseline Assessment Memorandum (BAM). BAMs provide a benchmark to

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[78]*PPBS Training Course, op. cit.*, p. 56.

[79]Secretary of the Navy Instruction 5000.16E, "Department of the Navy Planning, Programming, and Budgeting System (PPBS)," enclosure (2), p. 2, 31 March 1986.

determine the adequacy of resource allocation in the Sponsor Change Proposals/Sponsor Program Proposals (SCPs/SPPs).[80]

The Investment Balance Review (IBR) is conducted by the Assessment Division of the DCNO for Resources, Warfare Requirements and Assessments (N81). The IBR provides a process to continually review and update key DON issues brought forth in the JMAs and SAs. It addresses Navy capabilities and the tradeoffs required with fiscal and other real-life constraints to combine assessment results into one complete Navy investment strategy. This assessment/review process takes the place of the Warfare Appraisals, Summary Warfare Appraisal, and Readiness and Sustainability Appraisal.

After presentation of the JMA and SA proposals, the Resources and Requirements Review Board (R^3B) conducts meetings to discuss the Investment Balance Review proposals. Upon completion of this review, the DCNO for Resources, Warfare Requirements, and Assessments (N8) publishes program guidance to the Resource Sponsors directing them to incorporate IBR decisions into their Sponsor Program Proposals (SPPs). Fiscal guidance is also provided to establish tentative sponsor "toplines", i.e., the allocation of total Navy resources among sponsors. With this final update, Program

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[80]"N801 Desk Top Guide," *op. cit.*, p. 3-6.

Assessments come to an end and the Program Development phase begins.[81]

b. POM Development

Two documents must be issued prior to commencing the POM development phase, shown in Figure 3-3. First, the SECDEF issues the Defense Planning Guidance (DPG). Then, the Secretary of the Navy and the Chief of Naval Operations provide programming guidance for POM development based on JMAs and SAs, the Investment Balance Review, and CINC/Component Commander inputs. The Programming Division (N80) takes this guidance and develops the DON Consolidated Planning and Programming Guidance (DNCPPG). The DNCPPG provides SECNAV guidance on policy and high interest items to resource sponsors. It also allows the CNO to provide further technical guidance for POM preparation and serves as the basis for program development for resource sponsors.

Fiscal guidance in the programming phase begins with SECDEF distributing shares of the expected budget to the military departments with Total Obligational Authority (TOA) controls for each year of the FYDP. The Navy then divides its share into a blue/green split between the Navy and the Marines Corps. CNO (N80) then further allocates the Navy's share among

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[81]*Ibid.*

Figure 3-3

Source: *PPBS Training Course, op. cit.*, p. 60

the resource sponsors based upon historical execution and the BAMs.[82]

Sponsor Program Proposals (SPPs) represent the major initial proposals for the Navy's POM. Using the latest guidance and information derived in the Program Assessment phase, resource sponsors adjust and update their programs so that the SPPs comply with the guidance set forth in the DPG and DNCPPG. Additionally, the SPPs must address the disposition of the CINC IPLs and claimant inputs.

When the SPPs are completed, the resource sponsor must then present them to the Program Development Review Committee (PDRC). The PDRC is chaired by CNO (N80) and consists of flag-rank representatives from each of the DCNOs, ACNOs, and major staff offices serving CNO, as well as representatives from SECNAV. This is the first sounding board for the SPPs, and gives resource sponsors as well as OPNAV the opportunity to evaluate the programs and make recommendations for changes. Sponsor Program Proposal Documents (SPPDs) are prepared to record major changes to the resource sponsor's program.

Following the SPPs, resource sponsors prepare Post-SPP Assessments. These are written reports that provide an evaluation of programs as proposed in SPPs. The Post-SPP Assessments analyze the degree to which the SPP funding meets guidance and achieves the required program balance.

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[82]*PPBS Training Course, op. cit.*, p. 62.

Assessments are performed in such areas as manpower, personnel and training, and logistics.[83]

The last portion of the Program Development phase is Internal Review. The Requirements and Resources Review Board (R^3B), chaired by N8, reviews JMAs, SAs, and SPPs, and makes adjustments to the SPPs via "ZOWs" (there is no formal translation for ZOW).

The next level of review is the Navy Staff Executive Steering Committee (ESC). The ESC is chaired by the CNO and includes the VCNO and the Vice (three-star) Admirals, and provides CNO decisions on policy issues.

The decisions reached by the ESC form the basis for the Tentative POM (called the T-POM). The Programming Division (N80) consolidates and balances the SPPs as adjusted by the ZOWs. The T-POM is then brought before the Department of the Navy Program Strategy Board (DPSB).

The DPSB is comprised of the SECNAV, Under Secretary of the Navy, CNO, CMC, and the Assistant Secretaries of the Navy. They review the T-POM in pillar sections (force structure, modernization, readiness & manpower, and sustainability), review the U.S. Marine Corps POM, and review responses to CINC IPLs. Programs are rebalanced to meet DPG

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[83]CNA, *Building the Navy POM, op. cit.*, p. 21.

and fiscal constraints, and then the final POM is produced and ready for delivery to OSD.[84]

c. POM Delivery

The POM delivery phase, shown in Figure 3-4, is also referred to as "end game" because at this stage the POM is complete. Both the POM and the FYDP for all three services are passed to the Office of the Secretary of Defense (OSD). They are screened by Program Analysis and Evaluation (PA&E) and the CINCs for issue development. Issues are developed when either PA&E or the CINCs do not concur with the service's POM, and are resolved in OSD Program Review.[85]

d. OSD Program Review

The submission of the POM to OSD signals the beginning of the defense program review by OSD under the purview of the Defense Planning and Resource Board (DPRB)(see Figure 3-5).

The OSD Program Review provides an opportunity for senior leadership in the DPRB to review the results of program and policy initiatives. The program review focuses on the contents of the POM, asking the following questions:

- What capabilities are being provided?
- Are the capabilities consistent with the DPG and other guidance?
- What future changes in capabilities can be expected?

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[84]*PPBS Training Course, op. cit.*, pp. 67-68.

[85]*Ibid.* pp. 69-70.

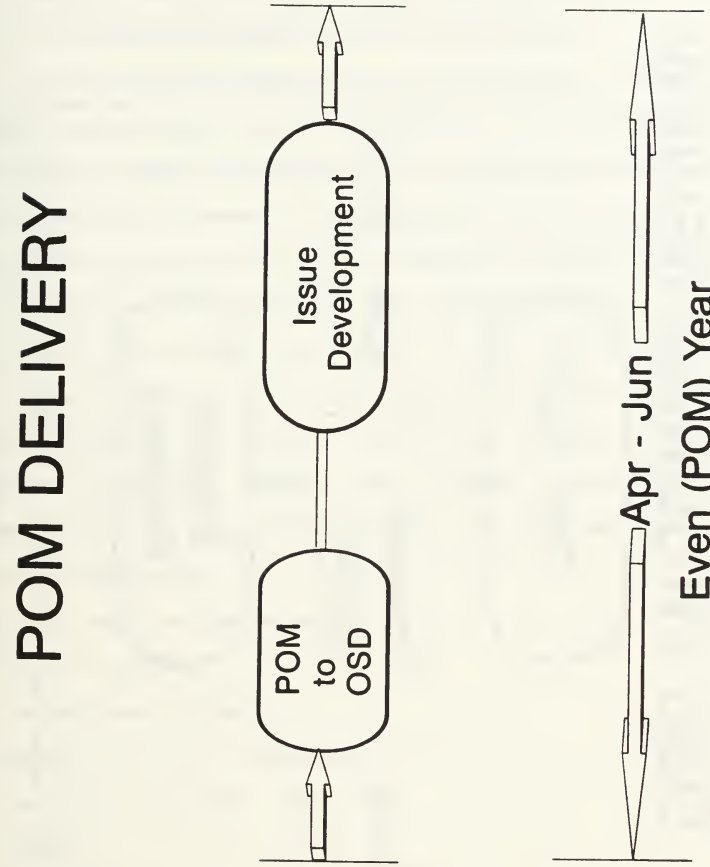

Figure 3-4

Source: *PPBS Training Course, op. cit.*, p. 69

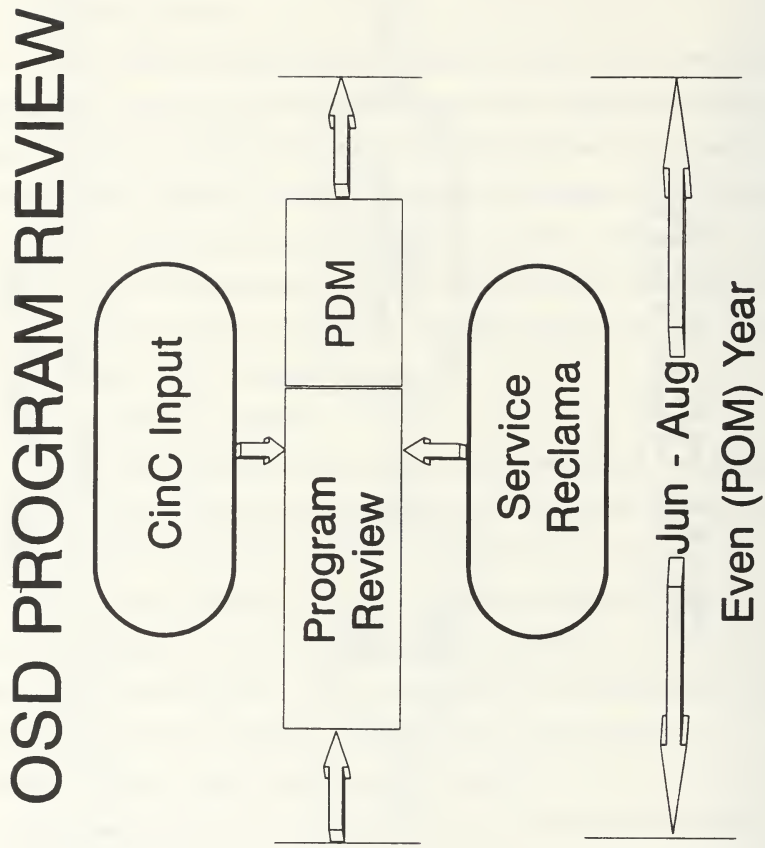

Figure 3-5

Source: *PPBS Training Course, op. cit.*, p. 71

Findings from the program review will influence future DoD programs, the content of the Program Decision Memoranda (PDMs), and identify needs for special studies.[86]

The review is constructed using questions, issues, and analyses provided principally by the Assistant SECDEF (PA&E). The POM is reviewed for program differences between estimates or alternatives proposed by the OSD staff and the service POM submissions. Differences are developed as issues for review and evaluation by the DPRB and are brought together in Issue Books which are formally presented to the DPRB by the PA&E staff. Issue Books reflect the OSD position (called a mark against the service's input), the service's position (called a reclama against OSD's mark), CINC input, and a recommendation to the DPRB. Issues are grouped into the following categories:

- Policy and risk assessment
- Nuclear forces
- Conventional forces
- Modernization and investment
- Readiness and other logistics
- Manpower
- Intelligence
- Management initiatives[87]

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[86]"N801 Desk Top Guide," *op. cit.*, p. 3-3.

[87]CNA, *Building the Navy POM, op. cit.*, pp. 22-23.

The DPRB considers each Issue Book and makes a recommendation to SECDEF. After reviewing the recommendations, SECDEF forwards his decisions to each service and defense agency in the form of Program Decision Memoranda (PDM). The PDM records SECDEF decisions on the POM and forms the basis for the development of the budget request to Congress.[88]

D. BUDGETING

The budgeting phase of the PPBS involves translating approved programs into annual funding requirements. The military services must justify the funds to be appropriated by Congress and then subsequently manage those funds.

The budget phase consists of three major segments:

- Budget formulation and review within the military services
- Overall DoD budget review by SECDEF, Director of the Office of Budget and Management (OMB), and the President
- Justification, execution, and management of the budget once approved by Congress[89]

Once the individual services have prepared their budget submissions, OSD segregates the service budgets into discrete segments for purposes of review and decision with OMB. The OSD (Comptroller) staff reviews and analyzes each program; differences result in the preparation of Program Budget Decisions (PBDs). The PBD highlights problems with program

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[88]"N801 Desk Top Guide," *op. cit.*, p. 3-7.

[89]CNA, *Building the Navy POM, op. cit.*, p. 6.

milestones or funding and permits SECDEF to examine DoD programs prior to meeting with the President and the Director of the Office of Management and Budget (OMB) to resolve final levels of Defense spending. Program Budget Decisions provide one or more alternative recommendations to meet a defined objective. For example, PBD 742 was issued on December 14, 1991, to create the Defense Health Program Appropriation.

Major Budget Issues are identified by the service Secretaries at the conclusion of the PBD review and are discussed by SECDEF and the service Secretaries at a special meeting provided for their resolution. Issues are restricted to those which have significant impact on the Services.[90]

After final approval by SECDEF, the service's budgets are consolidated into a DoD budget submission and later incorporated into the President's budget.

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[90]"N801 Desk Top Guide," *op. cit.*, p. 3-7.

IV. ESTABLISHMENT OF THE DHP APPROPRIATION

A. RATIONALE

The Planning, Programming, and Budgeting System (PPBS) is a management tool used by Department of Defense (DoD) leaders to apply rational decision making techniques to the allocation of resources to meet national security objectives. At the heart of the PPBS philosophy is cost-effectiveness: providing the most defense for a given cost, or a given level of defense at the least cost.

While DoD medical leaders have continued to strive for better quality and availability of health care, the decreasing overall DoD budget has forced all managers to focus on identifying means to control and cut costs. [As an entitlement program, defense health benefits must be provided to any qualified person i.e., active duty personnel, retirees, and dependents of active duty personnel, retirees, and deceased service members]. Because a certain level of health care is mandated by law to these personnel, the role of the PPBS for the medical mission is to determine how resources will be allocated to provide these benefits.

The creation of the Defense Health Program (DHP) appropriation - the history and specifics of which will be discussed later in this chapter - is a step in the direction

of recognizing this requirement. Funding from the three military services' Operations and Maintenance (O&M), Procurement, and Research, Development, Test and Evaluation (RDT&E) accounts have been consolidated into one central account under the management and control of the Assistant Secretary of Defense for Health Affairs (ASD(HA)). Funding for active duty military personnel is included in the consolidated medical Program Objective Memorandum (POM) but is transferred to the Military Departments for budget execution. The ASD(HA) is now responsible for all three phases of the PPBS for the Military Health Services System of DoD.

The Military Health Services System (MHSS) is an enormous organization. It is comprised of the three military departments (Army, Navy, and Air Force) and three field activities: the Defense Medical Support Activity (DMSA), the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), and the Uniformed Services University of the Health Sciences (USUHS).

The primary mission of the MHSS is to provide medical services and support to the armed forces during military operations and to service members, their dependents, and other beneficiaries in peacetime.[91] The role of the three military departments and OCHAMPUS is to provide the required medical

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[91]U.S. Department of Defense, *Defense Health Program Amended FY 1992/FY 1993 Biennial Budget Estimates*, p. 1, January 1992.

services. The DMSA provides information system, facility planning, and program support (e.g., planning, programming, and budgeting for DoD medical facility construction projects) for the MHSS. The mission of USUHS is to educate and train medical personnel to meet the combat and peacetime needs of the armed forces.[92]

To accomplish the medical mission, the MHSS employs an active work force of 200,000 military and civilian personnel and an additional 200,000 reserve personnel. With activities throughout the world, it controls and maintains 148 hospitals, 554 medical clinics, more than 300 dental clinics, and hundreds of medical activities organic to operational combat units. The three military departments, together with the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), provide medical services to nearly 9 million beneficiaries.[93] Fixed military medical facilities operating worldwide maintain over 14,000 operating beds, admitted over 158,000 patients for care, and provided care for over 11,650,000 people on an outpatient basis.[94]

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[92]U.S. Department of Defense, Office of Assistant Secretary of Defense (Health Affairs), *Organization and Functions*, pp. 16, 22, December 1990.

[93]Lanier, Jack O., Dr. P.H., FACHE, and Colonel Boone, Charles, USAF, Ph.D., FACHE, "Restructuring Military Health Care: The Winds of Change Blow Stronger", p. 121, *Hospital and Health Services Administration*, v. 38:1, Spring 1993.

[94]Washington Headquarters Services, Directorate for Information Operations and Reports, *Department of Defense Selected Medical Care Statistics*, Quarter ending 31 December

Maintaining an organization of this size and complexity requires a tremendous amount of financial resources. Due to technology, physician specialization, and other miscellaneous factors, medical costs in the United States have escalated at a rate far above inflation. The Department of Defense (DoD) has not been immune from these rising prices and, as displayed in Table 4-1, has witnessed a rapid growth in both the cost of health care and the percentage of DoD funding used to provide medical services to its constituency.

TABLE 4-1:MEDICAL CARE SPENDING IN THE DEFENSE BUDGET ($B)[95]

	1984	1990	% Change
Total Budget Authority	258,150	292,999	13
Health Care Spending			
CHAMPUS	1,254	3,119	149
Direct	5,934	10,971	85
Total Health Care Spending	7,188	14,090	96
Health Care as % of Budget	2.8	4.8	71

Department of Defense (DoD) health care costs in nominal dollars grew at an average annual rate of over eight percent from Fiscal Year 1985 to Fiscal Year 1991. While this was less than the ten percent annual growth rate experienced in the civilian economy over the same period, the overall DoD budget

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1991. Figures do not include number of personnel receiving care from field medical units.

[95]Congressional Budget Office.

grew at less than one percent in nominal dollars during this time.[96]

The Program Objective Memorandum (POM) for the Defense Health Program (DHP) appropriation for FY 1994-1999 requested funding of nearly $15.6 billion for FY 1994, and a modest 3.7 percent average annual growth for the ensuing five fiscal years.[97] This represents roughly 5.8 percent of the overall DoD budget for FY 1994. Clearly the trend points toward an ever increasing portion of the diminishing DoD budget being consumed by the medical program. In FY 1992, the medical program accounted for 5.2 percent of the overall DoD budget, 6.2 percent of military personnel, and 5.6 percent of civilian personnel. By FY 1999 the medical program, growing relative to the declining overall DoD budget, will represent approximately 6.3 percent of the overall DoD budget, 6.8 percent of military personnel, and 5.9 percent of civilian personnel.[98]

Prior to the creation of the DHP appropriation, the three military departments and the three field activities all independently planned, programmed, budgeted, and executed their respective budgets. While the three military departments consumed over 90 percent of health care fiscal resources, it

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[96]U.S. Department of Defense, *Defense Health Program (DHP) Program Objective Memorandum (POM) FY 1994-1999*, p. 1, 1992.

[97]*Ibid*. p. v.

[98]Kearns, P., COL, and Norris, J., "Defense Health Program Budget Detail, Trends, and Issues", 7 April 1993.

was difficult to calculate exact expenditures because each service programmed and accounted for resources in a different manner. For example, the Air Force used Program Elements (PE), the Army used decision packages, and the Navy used Activity and Sub-Activity Groups (AGs/SAGs) to account for Operations and Maintenance (O&M) resources.[99]

Additionally, some indirect costs of performing the medical mission "hidden" in programs such as Base Operating Support were not readily extractable for calculating costs. The combination of these and other factors made it difficult to cull relevant data from each of the services in order to establish the true cost of providing for the overall DoD medical mission.

Given the acceleration of health care costs and decreasing total DoD budget, it became imperative that action be taken to control health care costs. The creation of the Defense Health Program (DHP) appropriation is a first step towards the goal of cost containment. Accumulating costs in a single appropriation will make costs more visible. Once the costs are made visible and are identified, steps can be taken to make rational cost-containment decisions.

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[99]Interview between Lieutenant Colonel L. Ongstad, USAF, Office of the Assistant Secretary of Defense (Health Affairs), Washington, D.C., and the author, 11 March 1993.

B. BACKGROUND

The organizational and management structure of the Department of Defense (DoD) Military Health Services System (MHSS) has been an issue for a number of years. In 1949, the Chief of Staff of the U.S. Army, General Dwight D. Eisenhower, recommended to the Secretary of Defense (SECDEF) that the MHSS be studied and measures be taken to unify the three military department's medical services.[100] The issue of reorganization has subsequently been studied every four to six years and, although there have been incremental modifications, the services have rejected major organizational changes in favor of maintaining autonomous control over their health care systems.[101]

The traditional Military Health Services System is comprised of basically four independent health care providing organizations. Each of the three military departments, headed by a service surgeon general, has managed and administered their own organization. The fourth system of providing health care, CHAMPUS, has been managed by the Assistant Secretary of Defense (Health Affairs)(ASD(HA)). The service surgeon generals report to their respective service chief (e.g., the

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[100]U.S. Department of Defense, Director of Administration and Management, *Review of the Department of Defense Organization for Health Care*, p. 5, March 1991.

[101]Wright, H.J., Colonel, MC, USA, *The Economics of the Department of Defense Health Care System*, Individual Study Project, U.S. Army War College, Carlisle Barracks, Pennsylvania, 2 April 1992.

Surgeon General of the Navy reports to the Chief of Naval Operations) who in turn report to their respective service secretary (the Secretary of the Navy in this example).[102]

In the past few years, as medical costs have consumed an ever increasing portion of available DoD funding, the debate over the best organizational structure to provide cost-effective medical care in the Department of Defense has intensified. Together with the national debate over reform in civilian health care, both Congress and the press have questioned the management and use of resources in the MHSS. The charges have included that there is no single person accountable for the program, that the system is riddled with waste, and that it consistently exceeds budget.

In a period when the armed forces are downsizing and budgets are being reduced, some support functions for the three military departments are being consolidated into single DoD entities. Accordingly, proposals both internal and external to DoD have been made to merge the three services' medical organizations into a single Defense Health Agency (DHA) to meet the military mission requirements.[103]

Proponents of maintaining the current organizational structure, however, point to the fact that military health care costs, while rising, have increased at a lower rate than

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[102]Lanier and Boone, *op. cit.*, p. 123.

[103]*Ibid.* pp. 122-123.

experienced in the civilian economy. Additionally, the MHSS' mission of providing health care for service members and other beneficiaries is being met. Therefore, major overhaul of the system and structural reform is not required.[104]

C. CHRONOLOGY OF EVENTS

For nearly fifty years, consolidation and centralization of military health care has been studied and debated. At the heart of the matter has been the role of the Office of the Assistant Secretary of Defense (Health Affairs)(OASD(HA)) in achieving cost efficiencies. While the effectiveness of the relationships between the service surgeon generals and ASD(HA) has been influenced by the personalities of those holding these offices, the formal authority of ASD(HA) to manage and implement congressional and Secretary of Defense (SECDEF) initiatives has been limited. In an effort to expand the authority, command, and control of ASD(HA) over military health care, the ASD(HA)'s charter has been revised as recently as 1989 and twice in 1991.[105]

The driving force behind ASD(HA) charter revisions has been Congress. The Defense Authorization Act for FY 1989 expressed the need for developing a unified management

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[104]*Ibid.* p. 123.

[105]U.S. Department of Defense, Office of the Deputy Secretary of Defense, *Strengthening the Medical Functions of the Department of Defense*, 1 October 1991.

approach for DoD medical programs. A provision in the FY 1990 House Appropriation Committee Report on the Defense Appropriation Act directed the Department of Defense to reorganize its medical program under the control of one individual. This provision was subsequently rejected by the Senate Appropriations Committee. In the FY 1991 Defense Appropriations Act, the Conference Appropriations Committee Report directed DoD to prepare and submit a plan to centralize medical programs under the Assistant Secretary of Defense (Health Affairs).[106]

In response to this congressional interest, the ASD(HA), Dr. Enrique Mendez, submitted a *Report to Congress on the Reorganization of Military Health Care* in June 1990. In his report, Dr. Mendez proposed maintaining the current structure of the Military Health Services System until he was able to reorganize the ASD(HA) staff to handle consolidation.[107]

A Defense Management Review (DMR) of the health care organization and operation was conducted later in 1990 and, on 3 October 1990, the first iteration of Defense Management Review Decision (DMRD) 970 was made available for comment. This Decision proposed the creation of a Defense Health Agency

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[106]*Review of the Department of Defense Organization for Health Care, op. cit.*

[107]U.S. Department of Defense, Office of the Assistant Secretary of Defense (Health Affairs), *Report to Congress on the Reorganization of Military Health Care*, June 1990.

(DHA) into which DoD health care functions would be consolidated.[108]

In response to DMRD 970, ASD(HA) once again argued that consolidation at this time would undermine his reorganization initiatives, destroy his fragile relationship with the service surgeon generals, and "threaten the link between the services' operational war fighting forces and vital medical support".[109]

As a result of internal disagreements among DoD agencies regarding the value of reorganization of the Military Health Services System, the DoD Director of Administration and Management was tasked with conducting a study on the issue. This study was completed in March 1991 and provided DoD with three reorganization options.

The first option was to strengthen the role of ASD(HA). In this option, ASD(HA) would develop and be responsible for the execution of a unified DoD medical budget. The ASD(HA) would also be responsible for the preparation of annual planning guidance to be used by the three services in developing budgets and long-term fiscal plans.

The second option was to create a Defense Health Agency (DHA) which would be headed by a military flag officer or civilian who would report to ASD(HA).

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[108]U.S. Department of Defense, Office of the Department of Defense (Comptroller), *Defense Management Report Decision 970: Management of Defense Health Care*, 9 October 1990.

[109]Lanier and Boone, *op. cit.*, p. 125.

The third option was to establish a U.S. Medical Command which would be commanded by a flag officer and who would report to the Chairman of the Joint Chiefs of Staff.[110]

While the Department of Defense was reviewing these options, some members of Congress continued to press for organizational reform. In June 1991, the House Appropriations Committee Report on the FY 1992 Defense Appropriations Bill recommended creating a consolidated Coordinated Health Care Agency under the direction and control of ASD(HA).[111]

That same month, Congressmen Ralph Regula (R-OH) and John P. Murtha (D-PA) submitted a bill requiring DoD to establish a Coordinated Health Care Agency by January 1992. Although the bill was not enacted, it kept the issue alive for debate in Congress.[112]

However, congressional support for reorganization of the Military Health Services System was not unanimous. Some members felt that the reorganization proposals did not address the real problems facing the MHSS, and that time and resources

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[110]*Review of the Department of Defense Organization for Health Care, op. cit.*

[111]U.S. Congress, House of Representatives, Committee on Appropriations, Defense Subcommittee, *Report of the Committee on Appropriations*, 102d. Congress, 1st sess., 4 June 1991.

[112]U.S. Congress, House of Representatives, Committee on Appropriations, Defense Subcommittee, Proposed *Defense Coordinated Health Care Act of 1991*, 102d. Congress, 1st sess., 31 July 1991.

would be better used in developing strategies for a more cost-effective organization.[113]

The ASD(HA) was caught in the middle of the organizational reform debate. In August 1991, he directed the establishment of a joint working group to consider the matter of consolidation of military health care. The working group was charged to:

> recommend a credible, efficient mechanism for channelling health care responsibilities, authority, and resources from the Office of the Secretary of Defense to the Services in order to facilitate better management and achieve certain economies.[114]

The working group was comprised of representatives from the military departments, the Chairman of the Joint Chiefs of Staff, the DOD Comptroller, and the Office of the ASD(HA) and focused on three general areas of concern.

First, they explored the issue of how to contain military medical costs. The general perception of both DoD and congressional leaders was that the current system did not contain a satisfactory mechanism for cost containment.

Second, they addressed the organizational form and management structure which would best facilitate cost containment. At the crux of this debate was the perceived lack

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[113]Lanier and Boone, *op. cit.*, p. 126.

[114]U.S. Department of Defense, Office of the Assistant Secretary of Defense (Health Affairs), *Establishment of Joint Working Group to Consider Consolidation of Health Care Functions*, 26 August 1991.

of responsibility, accountability, and authority of the ASD(HA) in the current organization.

The final issue the working group addressed was the congressional perception that, left on their own, the military departments would divert funds fenced for medical programs to other uses.[115]

In addressing these concerns, the working group produced two options for further internal discussion. The first option was to create a senior-level group (called the "joint health staff") who would advise ASD(HA), coordinate service input on medical issues, and ensure compliance with ASD(HA) direction and guidance. The second option was to consolidate MHSS resources into a Defense Health Agency (DHA) which would report to ASD(HA).[116]

These two options were then further debated by the working group. While there was some concern that creating a joint health staff advisory council might undermine ASD(HA)'s accountability for DoD medical programs, it was generally agreed that there were many benefits to be realized from implementing this proposal. For instance, it would strengthen policy ties and facilitate coordination among ASD(HA) and the military services.

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[115]U.S. Department of Defense, *Report of the Joint Working Group to Consider Consolidation of Health Care Functions*, 4 September 1991.

[116]Lanier and Boone, *op. cit.*, p. 128.

The second option generated substantially more discussion. Concerns were raised that creating a DHA would derail ASD(HA)'s initiatives to improve access to care and cost containment. Establishing a DHA would require an enormous effort to formulate plans, coordinate activities, and make logistical arrangements.

A final concern dealt with the issue of authority and responsibility. If medical program funding was to be centralized under ASD(HA), then the requisite management authority over those funds should also be transferred. Otherwise, it would appear that ASD(HA) was the accountable entity for funding when in fact the military departments would still maintain the responsibility for executing the medical programs.[117]

After discussing the two alternatives, the working group proposed to the Secretary of Defense that a senior-level advisory council be established. The council would serve as a forum for ASD(HA) to receive advice on program matters and also provide ASD(HA) with input from the services to plan, program, and budget for the medical mission. The advisory council would advise and recommend resource allocation and reallocation, coordinate service approaches to health programs and medical readiness, provide input and feedback to ASD(HA) from the services on policy implementation, and ensure that

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[117]*Ibid.*, pp. 128-129.

health care policy and program decisions of the ASD(HA) were implemented.[118]

The working group chairman then briefed the ASD(HA) and the Deputy SECDEF on the group's recommendations.

D. THE DECISION

Acting on these recommendations, on 1 October 1991, the Deputy Secretary of Defense (DEPSECDEF) signed a memorandum designed to improve the functions of the Military Health Services System. The key components of this memorandum, which were later incorporated into Program Budget Decision (PBD) 742, were:

- Assign ASD(HA) as the sole DoD official responsible for the effective execution of the Department's medical mission.
- Place medical personnel, facilities, programs, funding, and other resources within the DoD under the authority, direction, and control of ASD(HA).
- Direct ASD(HA) to prepare and submit a unified medical program, providing resources for all medical activities included in the unified medical budget (including active military personnel end strength and funding; operational and maintenance funding to include civilian personnel end strength; procurement funding; research, development, test, and evaluation funding; and military construction funding). Exempted from this is funding for combat support and active military personnel which will be accomplished by the respective Service in its budget request.
- Appoint ASD(HA) to be the sole responsible person to present, defend, and justify the unified medical program and budget throughout the Department's PPBS.

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[118]*Report of the Joint Working Group, op. cit.*

- Establish a Defense Medical Advisory Council (DMAC) to provide advice to ASD(HA) in the execution of the DoD medical mission.

- Direct ASD(HA) to implement a medical care program that ensures maximum cost-effective coordination in the delivery of high-quality health care within certain geographic areas.[119]

The DMAC consists of the ASD(HA) as chairman, one civilian presidential appointee from each of the military departments, one general or flag officer from each military service, one general or flag officer designated by the Chairman of the JCS, and the president of the Uniformed Services University of the Health Sciences. Its role is to act as a middle-man between ASD(HA) and the military departments. The DMAC acts on behalf of ASD(HA) to ensure that his policies and initiatives are carried out by the military departments. The DMAC also provides a channel for the military departments to express their needs and concerns to ASD(HA).[120]

On December 14, 1991, the Deputy Secretary of Defense signed PBD 742 to consolidate all medical resources under the control of ASD(HA) and to make other required adjustments to the medical program.

This PBD established a separate and unified medical appropriation which included all medical resources that were currently contained in the various appropriations of the

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[119]U.S. Department of Defense, Office of the Deputy Secretary of Defense, *Program Budget Decision 742*, 14 December 1991.

[120]Lanier and Boone, *op. cit.*, p. 130.

military departments. Exempted from the consolidation were military personnel funds and resources in support of field/numbered medical units, hospital ships, and ship-board medical operations. To perform the increased planning, programming, and budgeting functions resulting from the consolidation, ASD(HA) was also granted additional funding to hire personnel to perform the functions.[121]

The provisions of PBD 742 consolidated the DoD components' medical resources currently contained in their Operations and Maintenance (O&M), Procurement, and Research, Development, Test, and Evaluation (RDT&E) appropriations into the Defense Health Program (DHP) appropriation effective 1 October 1992. Funding for medical facilities would continue to be reflected in the Military Construction account but administered by ASD(HA).

On 1 October 1992, the DHP appropriation would commence funding all direct costs of health care delivery as well as to reimburse host activities for base operations and other indirect support provided in accordance with negotiated reimbursable intra-service support agreements. Additional support required during the execution of these agreements would be negotiated between the ASD(HA) and the military

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[121] *Ibid.*

departments and adjustments reflected in subsequent program/budget decisions.[122]

The impact of these decisions has been significant. First, by consolidating medical resources and control over planning and programming, the ASD(HA) has tremendous power to influence the direction and course of military health care. Second, establishing the Defense Medical Advisory Council (DMAC) provides an ongoing official forum for exchange of information between ASD(HA) and the leadership of the Armed Services. The success and effectiveness of the DMAC may determine whether or not further organizational changes are necessary to achieve the goals of the MHSS.[123]

E. SUMMARY

The establishment of the Defense Health Program (DHP) appropriation as directed by Program Budget Decision (PBD) 742 has necessitated changes in the Planning, Programming, and Budgeting System (PPBS) for the three military departments. Prior to the creation of the DHP appropriation, the three services independently performed the three phases of the PPBS to meet medical requirements. With the consolidation of service health resources under the management and control of ASD(HA), the services must now coordinate their efforts with

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[122]*Ibid.*

[123]*Ibid.*

ASD(HA) to justify their programs and compete for scarce resources.

V. BUILDING THE POM FOR THE DHP APPROPRIATION

A. BACKGROUND

Program Budget Decision (PBD) 742 of 14 December 1991 directed the Department of Defense (DoD) to establish the Defense Health Program (DHP) appropriation to commence in Fiscal Year (FY) 1993. The three military departments (Army, Navy, and Air Force) were directed to transfer medical resources contained in their Operations and Maintenance (O&M), Research, Development, Test, and Evaluation (RDT&E), and Procurement appropriations for consolidation into the DHP effective 1 October 1992.[124]

Beginning in Fiscal Year (FY) 1993, the Defense Health Program (DHP) appropriation provided funding for support of world-wide medical and dental services to active duty forces and other eligible beneficiaries.

Over forty percent of the DHP funding is used to finance the costs of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS provides for the health care of eligible active duty dependents, retired members and their dependents, and the eligible surviving dependents of deceased active duty and retired members.

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[124]U.S. Department of Defense, Office of the Deputy Secretary of Defense, *Program Budget Decision 742*, p. 3, 14 December 1991.

In addition to CHAMPUS and military patient health care, the DHP also finances veterinary services, costs of medical command headquarters, specialized services for the training of medical personnel, and occupational and industrial health. Finally, this program provides funding for the acquisition of capital expense equipment and for basic and applied medical Research, Development, Test, and Evaluation (RDT&E).

The FY 1992 DoD Appropriations Act appropriated $8.1 billion of medical Operations and Maintenance (O&M) funds originally requested by the three services to the consolidated DHP appropriation under the control of the Assistant Secretary of Defense for Health Affairs (ASD(HA)). This represented the majority of medical O&M funds except for $0.6 billion to fund Navy Medical Base Operations Support and Air Force medical training which remained under the services' control.[125]

The amended FY 1993 President's Budget submission in February 1992 established the DHP appropriation of $9.5 billion in three budget activities - O&M, Other Procurement, and RDT&E - including over $3.9 billion in funding for CHAMPUS, and continued the central funding of medical construction in the Defense Agency Military Construction account.[126]

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[125]Kearns, P., COL, and Norris, J., *Defense Health Program Budget Detail, Trends, and Issues*, 7 April 1993.

[126]*Ibid.*

In the FY 1993 Defense Appropriation Act dated 5 October 1992, Congress approved the President's budget submission with the exception of the RDT&E funding. These funds, totaling $313 million, plus a congressional increase of $322 million, were returned to the three services and Defense Agency accounts where they had been carried prior to the establishment of the DHP appropriation.[127]

Thus, as of the start of FY 1993, the majority of medical program funding and activities were under the direction and control of the Assistant Secretary of Defense for Health Affairs (ASD(HA).[128]

The Navy alone transferred over $2 billion from its O&M account contained in Budget Activity 8 (Training, Medical, and Other General Personnel Activities) to the DHP for FY 1993. Among the Naval activities affected by this transfer were: Care in Regional Defense Facilities (Teaching Hospitals); Station Hospitals and Medical Clinics; and Care in Non-Defense Facilities (including CHAMPUS).[129]

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[127]U.S. Department of Defense, Office of the Deputy Secretary of Defense, *Program Budget Decision 041*, p. 3, 13 December 1992.

[128]U.S. Department of Defense, *Defense Health Program Amended FY1992/FY1993 Biennial Budget Estimates*, pp. 1-2, January 1992.

[129]U.S. Department of the Navy, *Justification of Estimates FY92/93 Budget Estimates*, pp. 3-8-103, 115, 121, February 1991.

In addition to the O&M transfer, Program Budget Decision (PBD) 742 directed the Navy to shift $37.4 million from its RDT&E (which was ultimately returned to Navy control by Congress) and $47.2 million from its Procurement accounts to the DHP.[130]

The ASD(HA) is now responsible for developing and submitting requirements for the Defense Health Program appropriation through the PPBS. Through the service Secretaries, he issues direction and guidance to the three services in the preparation of their Program Objective Memorandum (POM) submissions. The services continue to have the organizational assets and expertise to assist the ASD(HA) in all phases of PPBS to provide the medical activities required to meet the military departments' respective missions and goals. In addition to their assistance in the PPBS process, the three services continue to be responsible for the day-to-day management and operations of their respective activities.

B. ASD(HA) ORGANIZATION TO SUPPORT PPBS FOR THE DHP

The Assistant Secretary of Defense for Health Affairs (ASD(HA)) serves as the principal staff assistant and advisor to the Secretary of Defense (SECDEF) for all Department of

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[130]*PBD 742, op. cit.*

Defense (DoD) health policies, programs, and activities.[131] Prior to establishing the Defense Health Program (DHP) appropriation, the ASD(HA) did not play a major role in the planning and programming of medical resources for the three services. The three military departments had primary responsibility to plan and program for the medical resources required to meet their respective missions.

Strengthening the charter of ASD(HA) in the 1990s and issuing Program Budget Decision (PBD) 742 in December 1991 served two purposes. First, it gave ASD(HA) responsibility and accountability for the entire Military Health Services System (MHSS). For the first time, the PPBS for the three military departments and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) would be under the direction of one organization. Second, PBD 742 provided authority and funding for ASD(HA) to hire 52 new civilian personnel to administer the PPBS for the DHP appropriation.

With the new hiring authority and funding, the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) is now fully staffed to provide an in-depth review of independent service POM and budget submissions for consolidation into one Defense Health Program submission to the Secretary of Defense (SECDEF).

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[131]U.S. Department of Defense, Office of the Assistant Secretary of Defense (Health Affairs), *Organization and Functions*, p. 1, December 1990.

The Deputy Assistant Secretary (Health Budgets and Programs)(DASD(HBP)) is the primary assistant to ASD(HA) for coordinating and managing all OASD(HA) financial programs, budgets, and evaluation of programs. The DASD(HBP) develops OASD(HA) input to the Defense Planning Guidance; reviews the Program Objective Memorandum (POM); and provides OASD(HA) input on Program Decision Memoranda (PDMs), Program Budget Decisions (PBDs), and Defense Management Review Decisions (DMRDs) for incorporation into the PPBS.

Assisting the DASD(HBP) are two Executive Directors: one for Resources Management and the other for Program Review and Evaluation. The Executive Director of Resources Management is responsible for plans and policy development, programs, budget formulation and execution, and program and financial control. The Executive Director of Program Review and Evaluation is responsible for Health Program review and evaluation, research, and analysis.[132]

C. THE EFFECT OF THE DHP ON THE PPBS

1. Fiscal Years 1992 - 1993

The three services had each independently planned and programmed to produce their respective Program Objective Memoranda (POMs) for Fiscal Years (FYs) 1992 through 1997 (POM 92). Because of DoD biannual budgeting, the first two years of

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[132]*Ibid.*

POM 92 served as the basis for the budgets for FY 1992 and FY 1993. Program Budget Decision 742 was signed 14 December 1991, roughly one-quarter into the execution phase of FY 1992, and therefore did not effect the PPBS for that fiscal year.

The effect that PBD 742 had on the PPBS for FY 1993 was also minimal. Program Budget Decision 742 directed the establishment of the DHP appropriation effective 1 October 1992 (the beginning of FY 1993). However, by the time the PBD was signed on 14 December 1991, the Planning and Programming Phases for FY 1993 had already been completed; POM 92 had been completed the previous year. As a result, the only PPBS Phase of POM 92 that PBD 742 could impact was the Budgeting Phase.

The timing of the issuance of PBD 742 in December 1991 and the requirement for the Department of Defense' budget submission for FY 1993 as part of the President's budget submission to Congress in January 1992 left virtually no time for the Office of the Assistant Secretary of Defense (Health Affairs) to play an active role in the PPBS. As a result, the three services' budget estimates were basically totaled together under the DHP, and ASD(HA) provided oversight on the execution of the budget for FY 1993.

2. PPBS for FY 1994 - 1999

The first consolidated Program Objective Memorandum (POM) prepared for the Defense Health Program (DHP) appropriation was for Fiscal Years (FY) 1994-1999. Due to the

timing of the issuance of Program Budget Decision (PBD) 742, this was not a complete Planning, Programming, and Budgeting System (PPBS) cycle.

When PBD 742 was signed on 14 December 1991, the Planning and Program Appraisal (now Program Assessment) phases for the Program Objective Memorandum (POM) for Fiscal Years 1994-1999 had been in progress for over a year. The first Navy POM Serial (94-1) had been issued in August 1990 by the Office of the Chief of Naval Personnel (OPNAV) and had scheduled the Program Planning Phase to be conducted from September 1990 to November 1991, after which time the Program Development Phase would begin.[133]

As a result of this timing problem, the majority of program planning for the Department of the Navy (DON) had been completed prior to the establishment of the Defense Health Program (DHP) appropriation. The Summary Naval Warfare and Summary Readiness and Sustainability Appraisals (now the Joint Mission Assessments and Support Assessments) had been completed, and Navy Component Commanders had submitted point papers for each Integrated Priority List (IPL) item.[134]

In response to the establishment of the DHP appropriation, the Joint Chiefs of Staff (JCS) staff requested

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[133]Department of the Navy, Office of the Chief of Naval Operations, *Procedures for Program Objectives Memorandum (POM) 94*, Serial 801C/0U651531, 23 August 1990.

[134]*Ibid.*

the commanders-in-chief (CINCs) to submit IPLs specifically for medical-related items (called Medical IPLs or MIPLs). After the MIPLs were received by the JCS, they were segregated according to service responsibility and then sent to the respective service for action. Additionally, the entire package of MIPLs was sent to ASD(HA).[135]

To illustrate this MIPL process, CINCLANT might have submitted a MIPL to the JCS pertaining to a particular medical issue in the Norfolk, Virginia area. The JCS would determine that the Navy was the service responsible for addressing medical issues in this geographic area and forward the MIPL to the Surgeon General of the Navy and ASD(HA). The Surgeon General of the Navy and the Navy's Bureau of Medicine (BUMED) would then review the MIPL and ensure that the issue was addressed in the Navy POM input.

With the completion of the Program Planning phase, the Navy began the Program Development phase. There were several documents produced to guide the Navy in the development of their programs. Overall guidance for the Department of Defense (DoD) was provided in the Defense Planning Guidance (DPG). Programming guidance from the Secretary of the Navy (SECNAV) and the Chief of Naval Operations (CNO) based on the completed appraisals and CINC/Component commander inputs resulted in the

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[135]Interview between Commander D. Snyder, MSC, USN, Office of the Surgeon General of the Navy, Washington, D.C., and the author, 11 March 1993.

promulgation of the Department of the Navy Consolidated Planning and Programming Guidance (DNCPPG). The Assistant Secretary of Defense (Health Affairs) also provided Medical Program Guidance based on the DPG.

The applicable portions of the DNCPPG and ASD(HA) Medical Program Guidance which concerned the Navy's medical mission were then forwarded to the Surgeon General of the Navy. The Surgeon General of the Navy passed on the guidance to his Major Claimants (e.g., BUMED) for the development of POM inputs.[136]

The three military departments then independently prepared their own inputs for the Defense Health Program POM. For the Navy, the guidance provided by the DPG, DNCPPG, and ASD(HA) Medical Program Guidance was transformed into resources required to meet the Department of the Navy's medical mission. The individual services were required to submit resource requirements to the ASD(HA) in Program Element (PE) format. Program Elements, as described in Chapter III, consist of forces, manpower, and estimated costs associated with an organization, a function, or a project, and describe a mission as well as the responsible organization. For example, the mission of providing care in regional defense facilities is identified by Program Element 0807711. An

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[136]Interview between Commander D. Snyder, MSC, USN, Office of the Surgeon General of the Navy, Lieutenant Commander G. Ininns, MSC, USN, Office of the Assistant Secretary of Defense (Health Affairs), and the author, 11 March 1993.

alphabetical suffix at the end of this PE denotes the responsible organization: A for Army, N for Navy, F for Air Force, and D for a Defense Agency.

The POM inputs from the three services were submitted to ASD(HA) in Program Element format. Justifications of and comments on specific inputs were provided by the services for ASD(HA) review. Changes from previous years' submissions were explained, as were any other significant issues.

Upon receipt of the services' POM inputs, program personnel in the Resources Management Division at ASD(HA) combined the amounts listed in the POM inputs for each PE. Comments and issues from the services were likewise combined as required to justify the input. The resulting combined POM became the Defense Health Program (DHP) POM for FY 1994-1999.[137]

The DHP POM was then delivered by ASD(HA) to the Secretary of Defense (SECDEF). The ASD(HA) raised several concerns during the issue development portion of the POM Delivery phase. First, the medical program resources transferred from the military department in PBD 742 did not adequately fund outyear requirements, including a $175 million shortage from the Air Force and a $135 million shortage from

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[137]Interview between Lieutenant Commander G. Ininns, MSC, USN, Office of the Assistant Secretary of Defense (Health Affairs), Washington, D.C., and the author, 11 March 1993.

the Navy.[138] The ASD(HA) was able to realign resources in POM 94 to cover the program shortfalls through FY 1996. However, he identified the following projected funding shortfalls for the outyears: a shortage of $104 million in FY 1997, $602 million in FY 1998, and $1.17 billion in FY 1999.

Though PBD 742 transferred resources from the three services to the DHP, the ASD(HA) questioned the validity of the amount transferred. The ASD(HA) had provided feedback to the DoD Comptroller after PBD 742 was issued, contending that medical program funding approved in the FY 1992-1997 Program Decision Memoranda (PDMs) had not been correctly reflected in the Future Years Defense Plan (FYDP) due to an error. Because this error had not been corrected in PBD 742, the resources transferred by the three services to the DHP were understated.

There were several other issues which affected funding for all of the years in the FY 1994-1999 DHP POM. These issues included inadequate levels of resources transferred from the services to the DHP to maintain: Base Operations Support for Army and Navy medical and research facilities; the Occupational Health Program for the Navy; the continued operation of the Moody Air Force Base medical facility; and construction funds for Army medical training facilities.[139]

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[138]Kearns and Norris, *op. cit.*, p. 3.

[139]U.S. Department of Defense, *Defense Health Program (DHP) Program Objective Memorandum (POM) FY 1994-1999*, 1992.

The Air Force and Navy have agreed to reprogram funding to cover $160 million and $135 million respectively of their shortfalls. Moody Air Force Base, which was targeted for base closure but later removed from the closure list, was funded under PBD 041 in December 1992. Finally, the issue of Base Operations Support is being addressed in PBD 429 concerning the transition to Defense Business Operations Funds (DBOF).[140]

After discussion of these and other issues, the Programming Phase continued with the OSD Program Review cycle. Changes to the DHP POM submitted by ASD(HA) were made by the Secretary of Defense via Program Decision Memoranda (PDMs), which generally specified the individual service whose funding was to be adjusted. This ended the Programming phase for the DHP for FY 1994-1999 and began the Budgeting phase.

The budgeting phase, which began in the summer of 1992, commenced with reviews by the OSD(Comptroller) and OSD(PA&E). A final review of the budget submissions involving personnel from OSD and from the Office of Management and Budget (OMB) resulted in the issuance of Program Budget Decisions (PBDs) to make final adjustments to the budget. The Budgeting phase culminated with the submission of a two-year DoD budget request to the President for inclusion in his

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[140]Kearns and Norris, *op. cit.*, p. 3.

overall budget. The President's budget request for FY 1994 and FY 1995 was then submitted to Congress in January 1993.[141]

3. PPBS for FY 1996 - 2001

The most recent cycle of the Planning, Programming, and Budgeting System (PPBS) began in July 1992, and will develop a Program Objective Memorandum (POM) for Fiscal Year (FY) 1996 through FY 2001. Programming and budgeting for this cycle will culminate with the submission of a two-year budget for FY 1996 and FY 1997 in January 1995.[142]

This will be, from start to finish, the first complete PPBS cycle to be conducted for the Defense Health Program (DHP) appropriation. As in the past, the military departments will conduct the bulk of the Planning and Programming Phases to meet their medical mission requirements, with guidance from and inputs provided to the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)).

In anticipating the Program Objective Memorandum (POM) for Fiscal Years (FY) 1996-2001 (POM 96), it is assumed that certain events in the PPBS cycle will occur in a specific sequence and involve the identified organizations.

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[141]Interview between CDR Snyder, LCDR Ininns, and the author, *op. cit.*

[142]Department of the Navy, "Program Planning and Development Division (N801) Desk Top Guide," p. 3-2, rev. 17 February 1993.

There are two important factors which may have a large impact on programming for POM 96. First, with the change of administration in the Executive Branch, funding for the Department of Defense will probably be reduced below the levels planned for and used to produce the POM and Future Years Defense Plan (FYDP) for FY 1994-1999. The last four years of the FYDP become a starting point in developing the next POM and FYDP (in this case, the POM for FY 1996-2001). Therefore, an initial step in developing POM 96 will be to determine the extent of the proposed additional cuts.

The second factor which may impact the schedule for POM 96 is the prospect of producing a "mini-POM" for FY 1995. The services have been awaiting direction from the Secretary of Defense (SECDEF) to complete an abbreviated POM-cycle for FY 95. Should this happen, the impact on POM 96 is not known.[143]

Neither factor affected the Navy Program Planning Phase to develop POM 96, which commenced in August 1992 with the issuance of the first POM Serial to provide structure and guidance for the PPBS process.

At this point it is important to note that Program Planning for POM 96 and Program Review for FY 1995 overlap, and that the events to review the program for FY 1995 are then

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[143]Interview between Lieutenant Commander G. Ininns, MSC, USN, Office of the Assistant Secretary of Defense (Health Affairs), Washington, D.C., and the author, 12 May 1993.

used to shape POM 96. Therefore, the first part of this section will look at the sequence of events for Program Review of the FY 1995 budget (including the revised budget submission for FY 94), which will in turn guide the preparation of POM 96. Figure 5-1 provides an overview of the PPBS used to develop the FY 1994/FY 1995 budget submission. Figure 5-2 depicts the basic program development cycle and projected timelines for both the FY 1995 Program Review and the development of POM 96.

In September 1992 (and continuing throughout the PPBS cycle to produce POM 96), the revised Assessment Process commenced. As previously mentioned in Chapter III, the Assessment Process replaced the Appraisal Process and now consists of conducting six Joint Mission Area (JMA) and two Support Area (SA) Assessments.[144]

The assessment of the Navy medical mission falls within the Readiness, Support, and Infrastructure portion of the Support Area Assessment. This Assessment (or Appraisal under the old system) has been historically conducted by a Navy Medical Services Corps (MSC) officer assigned to the Assessment Division (N81) in the Office of the Chief of Naval Operations (OPNAV). However, the current MSC officer assigned to N81 is due to rotate in the summer of 1993 with no relief

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[144]U.S. Department of the Navy, "Program Planning and Development Division (N801) PPBS Flow Chart 1992-1994," rev. 27 November 1992.

Figure 5-1

Source: *PPBS Training Course, op. cit.*, p. 97.

Figure 5-2

Source: Wagoner, R.C., CAPT, USN, "Program Planning and Development Division (N801) Flowchart," 30 September 1992.

planned. Because the amount of medical funding over which the Navy now has direct control (e.g., funding for hospital ships) is relatively small, the full-time assignment of an officer to assess the program may no longer be cost-effective.[145]

In conjunction with the Assessment Process, the Investment Balance Review (IBR) began in September 1992. Also conducted by N81, the IBR summarizes and integrates the JMAs and SAs to ensure that the Navy successfully plans and programs to meet its missions and roles. The IBR is aptly named - it serves to ensure that there is a proper balance of invested resources in the different joint and support mission areas.

Starting in January 1993, the Resources Requirements Review Board (R^3B) then began reviewing the JMAs, SAs, and findings from the IBR. In addition, a new organization in the OPNAV reorganization, N83 (CINC Matters) began collecting component commander inputs for review by the R^3B. The result of the R^3B review was a revised FY94/95 budget. This revision was then passed to the Deputy Chief of Naval Operations (DCNO) for Resources, Warfare Requirements, and Assessments (N80) for final balancing and approval in February 1993. Included in

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[145]Interview between Lieutenant Commander R. Foster, MSC, USN, Office of the Chief of Naval Operations, Washington, D.C., and the author, 10 March 1993.

this balancing were the N81 conducted War Games and a synthesis of individual JMA/SA reviews.[146]

The FY 94/95 revised budget was then passed to the Navy Comptroller (NAVCOMPT) and DoD Comptroller for review for inclusion in President Clinton's budget submission to Congress. After congressional review, the FY 94 Defense Authorization and Appropriation bills will be passed. Recent history suggests that the FY 94 bills will be passed some time after the start of the fiscal year on 1 October 1993, and that a continuing resolution will be in effect until the bills are passed.

While the FY 94/95 budget was being passed to NAVCOMPT, the Program Review and Coordinating Committee (PRCC), chaired by N80 and including Surgeon General representatives, began determining the planning decisions which would be used to provide detailed guidance to the Resource Sponsors in reviewing the FY 95 program. The inputs of the PRCC were submitted to the Chief of Naval Operations (CNO) via the R^3B.

In March 1993, after CNO review, N80 developed program and fiscal guidance reflecting the planning decisions recommended by the PRCC. Among these decisions were that only "mini-BAMs" (Baseline Assessment Memoranda) should be

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[146]"N801 Desk Top Guide," *op. cit.*, p. 3-4.

conducted and that no IPLs (Integrated Priority Lists) were to be submitted.

Additionally, the Resource Sponsors were tasked with developing Sponsor Change Proposals (SCPs) for FY 1995 to reflect noted program changes and conducting "mini Post-SPP" (Sponsor Program Proposal) assessments.

In May 1993, the R^3B began review of these changes and delivered its recommendations to N80 for final balancing and approval. The resulting adjusted FY 95 budget will then be submitted to NAVCOMPT to begin the apportionment review.[147]

The work to date will result in N80 submitting an updated POM serial in August 1993 to define the process and set the schedule for POM 96. The R^3B will begin reviewing the JMAs, SAs, the findings of the IBR, and the component commander inputs collected by N83 in September and October 1993. In November 1993, the Assessment Division (N81) will conduct War Games and balance the investments across all areas to ensure that mission requirements will be met. Also in November, the PRCC will meet to recommend planning decisions to the CNO through the R^3B to guide the building of Sponsor Program Proposals (SPPs).

In December 1993, N80 will develop program and fiscal guidance to reflect these planning decisions. Baseline

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[147]*Ibid.*

Assessments will be conducted and Integrated Priority Lists prepared.

From December 1993 through February 1994, the Resource Sponsors will build their Sponsor Program Proposals based on SECDEF fiscal guidance passed through N80. After the post-SPP assessments are completed in February 1994, the POM enters the "end game." The POM will be reviewed by the R^3B, the Navy Staff Executive Steering Committee (ESC), and the Department of the Navy Program Strategy Board (DPSB), chaired by the Secretary of the Navy. Final pricing and balancing adjustments to the POM will be made by N80 in March 1994, with POM 96 to be delivered to NAVCOMPT and OSD in April 1994.[148] The OSD Program Review (sometimes referred to as the "summer review") will then begin.

D. SUMMARY

The establishment of the Defense Health Program (DHP) appropriation has not had a dramatic affect on the mechanics of the Planning, Programming, and Budgeting System (PPBS) employed by the three military departments. While the Assistant Secretary of Defense (Health Affairs)(ASD(HA)) is now more actively involved in the PPBS as the Resource Sponsor for medical programs, the services continue to perform much of

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[148]*Ibid.* p. 3-5.

the work to produce a Program Objective Memorandum (POM) and therefore retain some influence in the shaping of the POM.

Certainly the enhanced role of the ASD(HA) in the PPBS and the management of the Military Health Services System (MHSS) will have an impact on the services' POM submissions and the goals of the MHSS as a whole. The strengthened charter of the ASD(HA) will provide one central organization to view total DoD medical program costs and offer initiatives such as managed competition to reduce those costs.

However, a bigger question in reviewing the effects of establishing the DHP appropriation is what do we hope to accomplish with this new appropriation? If the goal of PBD 742 is strictly to reorganize the MHSS, it fails to address the overarching concern for cost containment.

Recent history tends to reflect an apparent inability of the PPBS to accurately predict the ultimate expenditures for the medical program in the Department of Defense.

A review of the Department of the Navy's medical programming history in Chart 5-3 displays the programming shortfalls for that service. The programmed funding is consistently and substantially below the actual (certified) expenditures for that fiscal year. The differences have been made up in budget execution, i.e., money has been shifted from other accounts into medical. As a point of clarification, POM 88 and the DHP allocation have the same symbol. Under the previous PPBS schedule, POMs covered a five year period, so

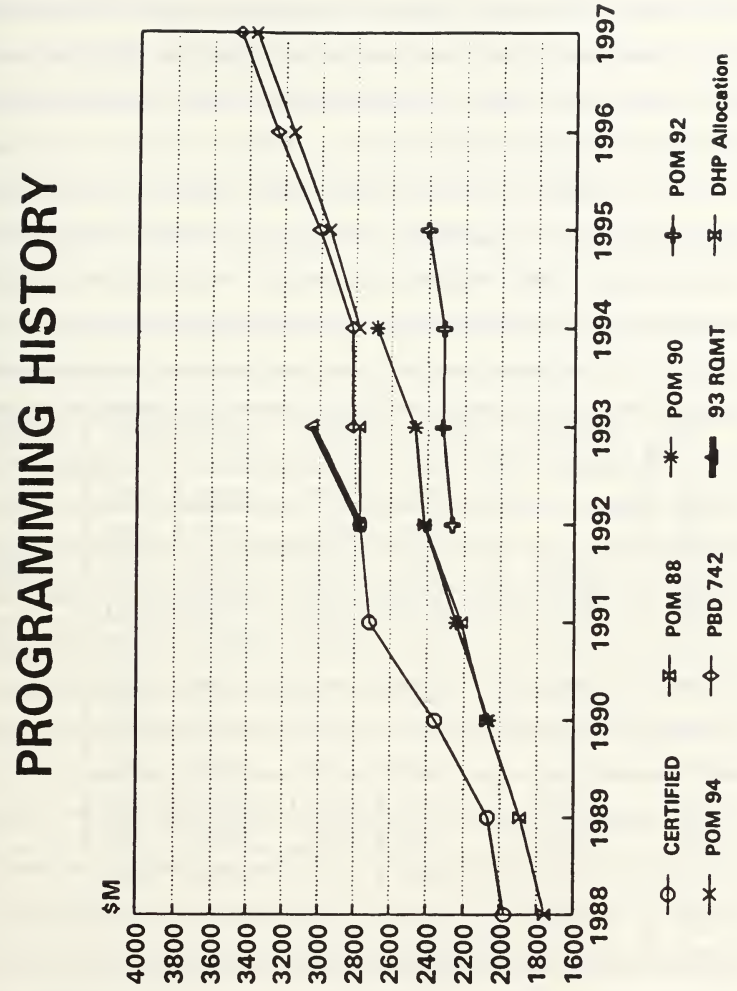

Chart 5-3

Source: U.S. Department of the Navy, Bureau of Medicine, 1992

that POM 88 projected budget estimates for FY 1988 through FY 1992. The DHP Allocation was effective for FY 1992 and is projected on the chart through FY 1993, so POM 88 and the DHP allocation overlap for FY 1992.

As a result of the individual service's problems in estimating medical program costs, DoD budget estimates for inclusion in the President's budget submission have been increasingly understated, as evident from Table 5-4.

Table 5-4: Defense Medical Program Funding History ($M)[149]

FY	Actual	Estimate (FY)	Amended (FY)	Amended (FY)
1993		8352.1 (92)	9507.5 (93)	
1992		7967.9 (92)	9323.5 (93)	
1991	9462.0	6693.2 (90)	7104.1 (91)	7555.2 (92)
1990	6971.1	6269.7 (90)	6283.0 (91)	
1989	6164.8	5659.5 (88)	5852.3 (89)	6017.6 (90)
1988	5701.6	5336.3 (88)	5681.8 (89)	
1987	4853.2	4552.7 (87)	4344.8 (88)	
1986	4333.4	4104.9 (86)	4106.1 (87)	
1985	3785.4	3910.2 (85)	3881.9 (86)	
1984	3588.6	3692.2 (84)	3609.5 (85)	
1983	3379.9	3053.8 (83)	3263.3 (84)	
1982	2961.9	2779.6 (82)	2747.6 (83)	
1981	2527.0	2569.5 (82)		

The first column is the Fiscal Year (FY) of the budget request. The second column is the actual expenditure on

[149]Congressional Budget Office, *Defense Health Program (DHP)/Medical Program*, pp. 23-117.

Department of Defense (DoD) medical programs. The third column is the initial estimate for the cost of the program for the cited fiscal year. Next to the number, in parentheses, is the Fiscal Year of the request in which this estimate was cited. For example, the third column for FY 1982 is 2779.6 (82). This means that the initial estimate of the cost of the DoD medical program for FY 82 (to commence 1 October 1981) in the FY 82 Budget Request (which would have been submitted in January 1981) was $2,779.6 million. The fourth and fifth columns are any noted amendments or changes to that initial estimate. Continuing with the above example, the fourth column for FY 82 is 2747.6 (83). This means that the estimate of the cost of the DoD medical program for FY 82 in the FY 83 Budget Request (submitted one-quarter of the way through FY 82 in January 1982) was now $2,747.6 million.

Analysis of the data in Table 5-4 shows that the difference between initial estimates and actual program costs from FY 1986 to FY 1990 rose from 5.28 percent to 10.06 percent.[150] Over the same time period, the differences between the amended estimates and the actual program costs rose from 5.25 percent to 9.87 percent. Prior to this period, estimates were generally close or even exceeded the actual program costs. However, it may be inferred that the differences

[150]Fiscal Year 1991 was not included in this analysis due to the unplanned expenditures as a result of Operation Desert Shield which skew the differences between estimated and actual.

experienced from FY 1986 through FY 1990 have occurred as a result of decreasing DoD budgets (adjusted for inflation) beginning in FY 1986 and have widened as the budget continues to shrink.

Through 1991, all the services had consistently (seven years running) underestimated the costs of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) accounts. Much of this shortage was due to the services' requirement to use general O&M inflation factors vice medical inflation factors to estimate and price expected CHAMPUS costs. The shortfalls in CHAMPUS required the Department of Defense (DoD) to submit supplemental budget requests to Congress. Because of the political sensitivity of denying medical care to patients due to DoD budgeting shortfalls, Congress has generally had little choice but to approve these supplemental requests.[151]

These facts can lead to several inferences. First, the PPBS is an inadequate management tool to develop an accurate budget estimate for an entitlement program. Second, current statistical and other predictive models used to estimate health care costs are inaccurate and in need of revision. Third, in the competition for scarce resources, medical programs do not compete well against operational programs and

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[151]Johnson, D. E., Colonel, MC, USA, *A Consolidated Military Health Care System*, Individual Study Project, U.S. Army War College, Carlisle Barracks, Pennsylvania, 1 May 1992.

therefore are funded with dollars remaining after other programs are fully funded. Fourth, events beyond the control of DoD drive costs well above what was budgeted. Fifth, because enrollment in DoD health care programs is not mandatory for beneficiaries, it is difficult to accurately predict year-to-year the number of beneficiaries who will use the MHSS. Or finally, there are indications that medical programs may be purposely underestimated to allow funding of other programs with the intent of seeking supplemental funding for medical programs when shortfalls occur.

For whatever reason, the apparent inability of DoD to submit accurate medical budget estimates to Congress played a large role in the creation of the DHP. It is too early to determine whether the establishment of the DHP will correct this problem.

VI. PROBLEMS AND PROSPECTS

A. OVERVIEW

The Planning, Programming, and Budgeting System (PPBS) is a management tool used by the Department of Defense (DoD) over the past thirty years to provide a rational decision-making process in the allocation of resources to competing programs. It is the process through which the Military Health Services System (MHSS) estimates patient loads and other operating requirements, applies cost formulas to those estimates, and produces a planned expenditure amount for budgeting purposes.

Although differences between the forecasted estimates and actual expenditures for the MHSS have been steadily increasing over the past decade, it is difficult to determine if the differences are a result of inefficiencies in the PPBS itself or the result of other factors.

Eligible beneficiaries are not required to enroll in a specific military health care plan. Based on a 1984 survey of beneficiaries conducted by the Department of Defense, the Congressional Budget Office estimated that 90 percent of active duty dependents and 57 percent of retirees and their families utilized the military health care system.[152]

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[152]Congressional Budget Office, Testimony of Robert D. Reischauer, Director, p. 2, 10 May 1993.

Some eligible beneficiaries, particularly retirees, have other sources to draw on to provide medical care coverage (e.g., Medicare). Others may have insurance obtained privately or through spousal employment. However, these so-called "ghost" eligibles can re-enter and utilize the Military Health Services System at any time.[153]

This Chapter will review the problems inherent in programming for an entitlement program such as DoD health care. It will also review some of the arguments for and against a composite military health service such as a Defense Health Agency in light of the consolidation of defense health resources into the Defense Health Program (DHP) appropriation. Finally, it will look at current initiatives and factors which will have an effect on the PPBS for the MHSS.

B. PROGRAMMING FOR AN ENTITLEMENT

The Defense Health Program (DHP) appropriation is unlike other appropriations such as Operations and Maintenance (O&M) in that it supports an entitlement program. People who meet certain criteria are by law eligible to receive specific medical services provided by the Department of Defense (DoD). As previously mentioned, there is an underlying uncertainty as to the number of eligible beneficiaries who will actually utilize DoD medical services. However, due to the entitlement

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[153]*Ibid.*

nature of health care, medical leaders in the DoD are limited in their ability to affect program costs. Given the congressionally-mandated population base that must be served, any cost savings to be achieved may be as a result of reduced services and/or lower quality of care.

The DHP is an anomaly in that it is an entitlement program incorporated within the largest single discretionary funding account in the Federal budget. The DHP currently represents nearly six percent of the overall Department of Defense budget and is predicted to continue to consume an ever-increasing portion of the funding.[154]

In this current period of decreasing DoD budgets and increasing entitlement funding, concerns over funding priorities for discretionary and entitlement programs are expected to grow.[155] The difficult issues that DoD leaders must wrestle with in the allocation of scarce resources between discretionary and entitlement programs are a microcosm of the problems the President and Congress face with the entire federal budget. Certainly entitlement programs must be funded, but to what level? It may be in the best interest of DoD leaders to fund an entitlement program such as the medical

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[154]Kearns and Norris, *op. cit.*, p. 1.

[155]U.S. Congress, Congressional Budget Office, *The Economic and Budget Outlook: Fiscal Year 1994-1998*, pp. 35-37, 1993 and Hager, George, "Entitlements: The Untouchable May Become the Unavoidable", pp. 22-30, *Congressional Quarterly*, 2 January 1993.

program, or even a major acquisition program such as the C-17, at the lowest supportable cost estimate. By budgeting at the lowest cost estimate rather than what may be a more realistic higher estimate, more funding can become available for other programs. Then, should shortfalls arise in the medical or acquisition programs, historical data suggests that supplemental budget requests for these programs would likely be approved by Congress.

With the change of administration in the Executive Branch in January 1993, DoD was handed even larger budget cuts than had been planned under the Bush administration. Leaders in the Department of defense must make rational decisions on how to allocate the reduced resources in the most cost-efficient manner in keeping with the administration's national strategic goals. This is likely to result in intense competition among programs within the PPBS system. In Strategic Forces, the Air Force provides bombers and missiles and the Navy provides submarines, and these programs can be competed against each other. However, as an entitlement program, defense health care really only competes against itself. There is no other entity within DoD to provide this service. Therefore, it is difficult to determine if there may be a less expensive way to provide health care services to DoD-beneficiaries.

A new concept being explored by the Assistant Secretary of Defense for Health Affairs to contain costs is a combination of "Managed Competition" and Capitation-Based Resource

Allocation. In the past, resources were allocated to Military Treatment Facilities (MTFs) based on workload measures. Capitation changes the resource allocation to a fixed amount per beneficiary being served by the MTF. The MTF commander will then utilize "Managed Competition" to attempt to make the most efficient use of these allocated resources by mixing in-house DoD medical services and private sector services. It is ASD(HA)'s opinion that this new concept is consistent with many of the features reportedly contained in the forthcoming national medical plan.[156]

In this time of decreasing budgets, the DHP appropriation poses significant problems for DoD. First, while the active duty and dependents patient base is decreasing, the retiree population is growing due to the effects of the all-volunteer force and longer life spans.[157] The proportion of retirees, their dependents, and survivors is estimated to grow from 45.2 percent in FY 1992 to 48.7 percent in FY 1995. This older population requires more complex and more expensive health care services.[158] While the retiree population may provide more opportunities for medical personnel to exercise their

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[156]U.S. Department of Defense, Office of the Assistant Secretary of Defense (Health Affairs), "Preparing the MHSS for Managed Competition and Capitation-Based Resource Allocation" (Draft), p. 1, 3 May 1993.

[157]CBO Testimony of Robert Reischauer, *op. cit.*, p. 9.

[158]U.S. Department of Defense, *Defense Health Program, Volume I, Budget Estimate Submission, Operations & Maintenance and Procurement FY 1994/FY 1995*, May 1995.

skills in surgery, their proportional increase is certainly a bad omen for cost reduction.

Second, the overall DoD budget is being decreased in real dollars and yet the Program Objective Memorandum for FY 1994-1999 calls for the DHP to grow at an average annual rate of 3.7 percent ($15.6 billion to $18.7 billion) and this is an optimistically low growth rate. Growth rates in the costs of civilian and military health care in the years preceding this POM were approximately ten and eight percent respectively.[159] With continued growth in mandatory spending programs such as the medical program or environmental clean-up and a decreasing budget available for all programs, funding for discretionary programs is squeezed and options for possible discretionary funding reduced.

To illustrate the difficult decision that must be made, assume that the national security strategy requires a certain level of defense (1080 units of defense effectiveness). The Department of Defense determines that the resources required to meet this strategy cost $120, of which $20 is in entitlements and $100 in discretionary funding. Each dollar of discretionary funding provides ten units of effectiveness and each dollar of entitlement spending provides four units.

If Congress appropriates only $90 for the defense budget, DoD has three choices. First, fully fund entitlements at $20

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[159]U.S. Department of Defense, *Defense Health Program (DHP) Program Objective Memorandum (POM) FY 1994-1999*, p. 1.

and somehow allocate a $30 budget cut to the discretionary programs. This, however, leaves defense at 780 units of effectiveness, implying that some national security objectives cannot be met.

The second choice is to zero out entitlements to fully fund discretionary programs. But $90 for discretionary programs would again fail to meet national security objectives (900 units of effectiveness versus the goal of 1080). And, of course, it is not a realistic option because DoD cannot choose to not fund its entitlement program.

The third option is to somehow spread the cut to both entitlement and discretionary programs and try to control costs and/or increase the effectiveness per dollar spent ratio to meet both the financial and operational objectives.

Although this is a very simplistic model, it does serve to illustrate some useful concepts associated with entitlement and discretionary funding.

First, when money gets tight, you can sometimes defer discretionary funding. Ships can be tied up to save fuel costs; maintenance can be delayed for a month or two to save on repair costs. But entitlements are mandated by law and cannot be deferred. If a person is entitled to a service and applies for it, he or she must receive the service.

Second, entitlement programs can be politically sensitive. Many entitlement programs are provided by the government to citizens who are perceived to be disadvantaged, e.g.,

unemployed, elderly, or ill. Recommending cuts in entitlement programs, however necessary, may be viewed as an attack on the poor and defenseless and therefore has been generally avoided.

Finally, rising entitlement costs in a period of declining budgets can seriously impair the primary mission of an organization and leave limited options for the organization's leaders. As the mandatory spending portion of the defense budget continues to grow, both absolutely and in relation to the discretionary portion, DoD leaders must continue to articulate to Congress the trade-offs between programs which must be made to stay within the imposed fiscal limitations, as well as congressional responsibility for the resulting size and shape of the armed forces.

C. A COMPOSITE MILITARY HEALTH CARE SYSTEM?

Since the establishment of the unified Department of Defense in 1947, numerous studies have been conducted to examine the Military Health Services System (MHSS).

The recommendations of these studies have been relatively consistent. While token acknowledgement of the unique aspects of each service is made, the studies have had difficulty in providing rational distinctions among the types of health care provided by the medical departments of each service. While there may be different requirements for uniformed personnel best handled by their specific service, the provision of

peacetime health care to DoD beneficiaries (e.g., retirees and dependents) is not service specific.

The majority of these studies have recommended at least some degree of unification of the MHSS, but these findings were largely ignored by the military. However, increased congressional attention to the subject of military health care finally resulted in the establishment of the Defense Health Program (DHP) appropriation and more centralized power in the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)).[160]

The establishment of the DHP may be a precursor to the consolidation of the three services' medical functions into one Defense Health Agency (DHA). In a study completed in September 1991, "guidance from the ASD(HA) indicated that creation of a single entity would be the only acceptable proposal".[161]

If in fact the Department of Defense is considering creating a single DoD agency for health care, then it is important to recount some of the historical arguments which have been raised both for and against this consolidation and

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[160]Johnson, D. E., Colonel, USA, *A Consolidated Military Health Care System*, Individual Study Project, U.S. Army War College, Carlisle Barracks, Pennsylvania, 1 May 1992.

[161]U.S. Department of Defense, Office of the Assistant Secretary of Defense (Health Affairs), *Report of the Joint Working Group to Consider Consolidation of Healthcare Functions*, p. 2, 4 September 1991.

the possible impacts on programming and budgeting for a consolidated Defense Health Agency.

Opposition to a consolidated Defense Health Agency has historically centered on three basic arguments. The first argument contends that removing Service Secretaries and Service military leaders from management of their respective medical departments will adversely impact their ability to integrate medical readiness with other service missions.

The counter to this argument is that Service leaders only manage their medical missions in theory. In reality, the services have very little discretion in the management of their medical assets. Because it is an entitlement program, the services to be provided and the eligible beneficiaries are largely determined by law. The services can use what discretion they have to determine how much health care is provided in-house and how much is provided through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). However, even this can hardly be described as management discretion. If you reduce the amount of care available at military health care facilities, eligible beneficiaries will seek care at civilian facilities and the CHAMPUS bill will be sent to the service.[162]

The second argument focuses on the services losing their ability to trade-off resources between medical and non-medical

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[162]Testimony of Robert Reischauer, *op. cit.*, p. 4.

uses. This argument has now been overtaken by events with the establishment of the DHP. By strengthening the charter of the ASD(HA) and creating the DHP, the services may have lost their ability to underestimate medical resource requirements, use this extra funding for non-medical uses, and submit a supplemental budget request to fund the resulting medical shortfalls. The flexibility to trade off resources between medical and non-medical uses has now moved to the Office of the Secretary of Defense (OSD).[163] However, even this flexibility is limited to the degree in which OSD can acquire accurate data from the services in the performance of their programming tasks in order to make rational trade-off decisions.

The third argument has focused on the doctor-patient relationship. The crux of this argument is that there is a special bonding between members of the same service that does not exist between members of different services. While their is some subjective validity to this argument, the bond has weakened over the past decade with the influx of civilian practitioners at military hospitals. Additionally, the high proportion of retirees served by the MHSS is provided care based on a geographic rather than service-specific basis.

Finally, a fourth and relatively new argument against establishing a Defense Health Agency is that the disruption

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[163]Johnson, *op. cit.*, pp. 4-7.

which would be caused by a potentially sizable reorganization would undermine attempts to institute new programs and occupy DoD leaders' time and energy which could be better utilized in exploring cost-saving ideas such as the Coordinated Care Program (CCP). But reorganization is inherently disruptive, and precedents do exist for successful consolidations, e.g., the Defense Logistics Agency. As to the argument that programs such as CCP will have to be put on the back burner, this fails to recognize that in either status quo or complete consolidation, the same people will be affected and the same offices accountable for the completion of both programs.[164]

The argument in favor of consolidation generally begins by noting that some efficiencies in delivering health care can be achieved and then leads to the resulting cost savings to be realized by implementing these efficiencies. Critics of the current system point to examples of redundancy where two or more of the services provide health care in the same geographic proximity (e.g., San Antonio, Texas, with the Army's Brooke Medical Center and the Air Force's Wilford Hall Medical Center). The argument is not that the facilities are underutilized but that certainly some economies of scale could be realized by combining the two.

Proponents of consolidation also contend that the current system does not integrate the peacetime and wartime medical

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[164]*Ibid.* pp. 4-10.

missions, and that a consolidated Defense Health Agency-type organization would allow for better review and management of required personnel resources. For example, it would not matter if one service had a shortage of certain qualified personnel as long as the other services had an off-setting surplus. This argument discounts the fact that certain personnel may not be interchangeable during the time of conflicts. Additionally, certain numbers of medical personnel might be transferred from active duty to reserve status; they are needed for a wartime mission but not to support peacetime activities.[165]

The arguments for consolidating the three services' medical departments into a single entity eventually focus on the cost savings to be realized through consolidation. In the above examples for instance, the redundancy claim does not focus on the fact that military health care facilities are underutilized, but that there is some degree of wasted taxpayer money by having separate administrative organizations. The second argument contends that there are certain qualified personnel not required by the military full-time which will again lead to cost savings.

As previously mentioned, critics of consolidation subscribe to the "if it ain't broke, don't fix it" theory. They point out that military health care cost growth rates have been lower than those experienced in the civilian sector,

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[165]*Ibid*. pp. 10-12.

which argues in favor of actually increasing the amount of in-house care offered by the MHSS. However, these lower growth rates may be a result of capped salaries of health care professionals and unmortgaged physical plants rather than any operating efficiencies.[166]

Recent studies have estimated that the Department of Defense could save $225 million per year by consolidating its medical functions.[167] While this is a considerable amount of money to the average tax-payer, it represents less than 1.5 percent of the total DoD health care budget and is on par with general accounting discrepancies. In other words, depending on the type of accounting system used, this savings could be realized on paper without reorganization. Second, these noted cost savings from consolidation presume the reduction of levels of bureaucracy which may or may not occur and, should they occur, may reappear at a later date.

The arguments raised both for and against a consolidated MHSS do not appear to address a more fundamental problem. Basic economic theory states that as price for a normal good (such as health care) decreases, the quantity demanded will increase. At some price, the quantity demanded will begin to exceed the quantity which suppliers are willing to provide.

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[166]*Ibid.* p. 12.

[167]*Ibid.* pp. 13-14.

Many beneficiaries in the military health care system pay little or nothing out-of-pocket for their health care and therefore have little reason to economize on the amount of health care they use. Adjusting for differences in use associated with sex and age, active duty dependents under the age of 65 living in the United States consumed about 720 days of hospital care per 1,000 people either through the direct care or CHAMPUS systems. This rate is roughly one-third higher than the civilian rate of 535 days per 1,000 people.[168]

A recent Congressional Budget Office study shows that even if the active duty force is drawn down to 1.2 million in 1997 (14 percent below the current estimate), health care costs directly related to patient care would rise from $9.5 billion in 1993 to $11.2 billion in 1998.[169] This escalation in health care costs occurs for several reasons.

First, the medical inflation rate has been almost twice as high as the rise in consumer prices. From 1982 to 1991, the medical component of the Consumer Price Index (CPI) has risen by 7.9 percent a year as compared to the overall CPI growth of 4.1 percent.[170] Second, active duty members and their dependents currently represent roughly one-half of the

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[168]Testimony of Robert Reischauer, *op. cit.*, p. 13.

[169]*Ibid.* p. 8.

[170]*Ibid.* p. 10.

population eligible for DoD health care benefits.[171] A 25 percent reduction in these beneficiaries represents only 12-13 percent of the population. The cost savings to be realized through this reduction in population are quickly eclipsed by medical inflation rates, and the drawdown of active duty personnel and their dependents further skews the proportion of elderly and generally less healthy individuals served by the MHSS.

The ultimate answer, for both the federal government and DoD, may be to enact measures to either limit access to or discourage frequent usage of federal health care systems. This may entail raising the eligibility criteria to a higher level, charging higher premiums per visit, or raising deductibles. How these options will be affected by the outcome of the Presidential Task Force on Health Care Reform is not known.

D. SUMMARY

As the overall budget for the Department of Defense (DoD) continues to decrease, several initiatives are being proposed to contain the rapidly escalating medical program costs. How these initiatives will affect the current structure of the Planning, Programming, and Budgeting System (PPBS) employed by DoD is not known. However, it is likely that the methodology

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[171]Congressional Budget Office, *Defense Health Program (DHP)/Medical Program*, p. 117.

used to plan and program for the Defense Health Program (DHP) appropriation will change.

Program Budget Decision (PBD) 041 of 13 December 1992 questions the proper pricing of the medical program. In PBD 041, the acting DoD Comptroller contends that, as a result of numbers computed by both the Defense Manpower Data Center and the DoD Comptroller, the Department of Defense is making decisions to provide and possibly expand medical services using cost estimates which understate the actual costs incurred. As a result of these understated costs, past planning and programming decisions on where and how to best provide care have been flawed.

For example, under the new pricing factor directed by the DoD Comptroller, the estimated cost per outpatient visit increased from $77 in FY 1992 to $100 in FY 1993. While some of this cost increase may be attributed to medical inflation, the majority is a result of new personnel pricing factors. Similarly, inpatient third party liability rates were increased from $707 in FY 1992 to $860 in FY 1993.[172]

The recent concept of Managed Competition and Capitation-Based Resource Allocation put forward by the Assistant Secretary of Defense for Health Affairs will also affect the mechanics of the Planning, Programming, and Budgeting System

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[172]U.S. Department of Defense, Office of the Deputy Secretary of Defense, *Program Budget Decision 041*, p. 6, 13 December 1992.

(PPBS). Under the current system, the services program and budget for health programs based on historical resource usage and workload. These reforms may be an incentive for the services to produce higher outputs and offer more services than may be medically necessary.

Under Managed Competition and Capitation-Based Resource Allocation, Medical Treatment Facility (MTF) commanders will receive a fixed per capita allowance based on the number of eligible beneficiaries to be served by their MTF. The MTF commander is then responsible for the most efficient use of these resources in filling the medical needs of his beneficiaries. This will entail a blend of services to be performed within DoD and civilian medical facilities. The incentive for the MTF commander is to stay within a prescribed budget and not to provide more costly care than is clinically appropriate.[173]

If the Planning, Programming, and Budgeting System (PPBS) is to remain the primary management tool employed by the Department of Defense in resource allocation, then developing a new system or organization to address the problems of the medical program must follow the PPBS logic. A threat (in this case an objective) must be defined. Strategies to achieve this objective must then be developed. The requirements and resources needed to achieve the different strategies must be

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[173]ASD(HA), "Preparing the MHSS...", *op. cit.*, p. 1.

identified and priced, packaged into a program, and become part of the budget.

Medical programs pose measurement problems similar to those in other programs. How clear and measurable is the objective? How much health care is enough? Can you ever have too much? What non-quantitative costs can be or have been ignored? If medical treatment facilities are closed and/or consolidated, how does this affect access to care and therefore the morale of active duty personnel? Are the driving assumptions of providing quality health care at least cost mutually exclusive? Can DoD contain or even reduce costs and still provide the same level of health care? Finally, how will the President's Task Force on Health Care Reform affect the current organization and the PPBS for the Military Health Services System?

Health care is certainly a difficult, complex, and expensive service which requires constant review. This paper has examined how the Department of Defense has determined requirements and resource allocation for the medical program in the past, and detailed some initiatives for the future. The organization and primary management tool to be used to support that organization in the performance of providing medical care in the future are the focus of current debate and may not be known for some time.

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